

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14445

14445

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LANGLEY PARK</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SAN. + HOSP</b>		d. STREET ADDRESS <b>1423 QUINWOOD ST.</b>	
3. NAME OF DECEASED (Type or print) <b>JULIA GLADYS RANSONE</b>		4. DATE OF DEATH <b>OCTOBER 6 1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-18-99</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>WILLIAM CROUCH</b>		14. MOTHER'S MAIDEN NAME <b>MATTIE ALLEY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>578-12-5085A</b>	
17. INFORMANT <b>Mary C. Ryals</b>		Address <b>13811 Downliss Dr. Rockville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>old coronary infarction</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1965</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 1966</b> to <b>Oct 6 1966</b> that (I) (we) last saw the deceased alive on <b>Oct 6 1966</b> and that death occurred at <b>9 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Ernesta Sarao</b>		22b. DATE SIGNED <b>Oct 6, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>ERNESTA SARAO M.D.</b>		22d. ADDRESS <b>2006 New Hampshire Ave Takoma Park</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<b>Burial</b>	<b>Oct. 10, 1966</b>	<b>Fort Lincoln Cemetery</b>	<b>Prince Georges Co., Md.</b>
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>		25a. REC'D BY REGISTRAR <b>Silver Spring, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 13 1966</b>	

MEDICAL CERTIFICATION

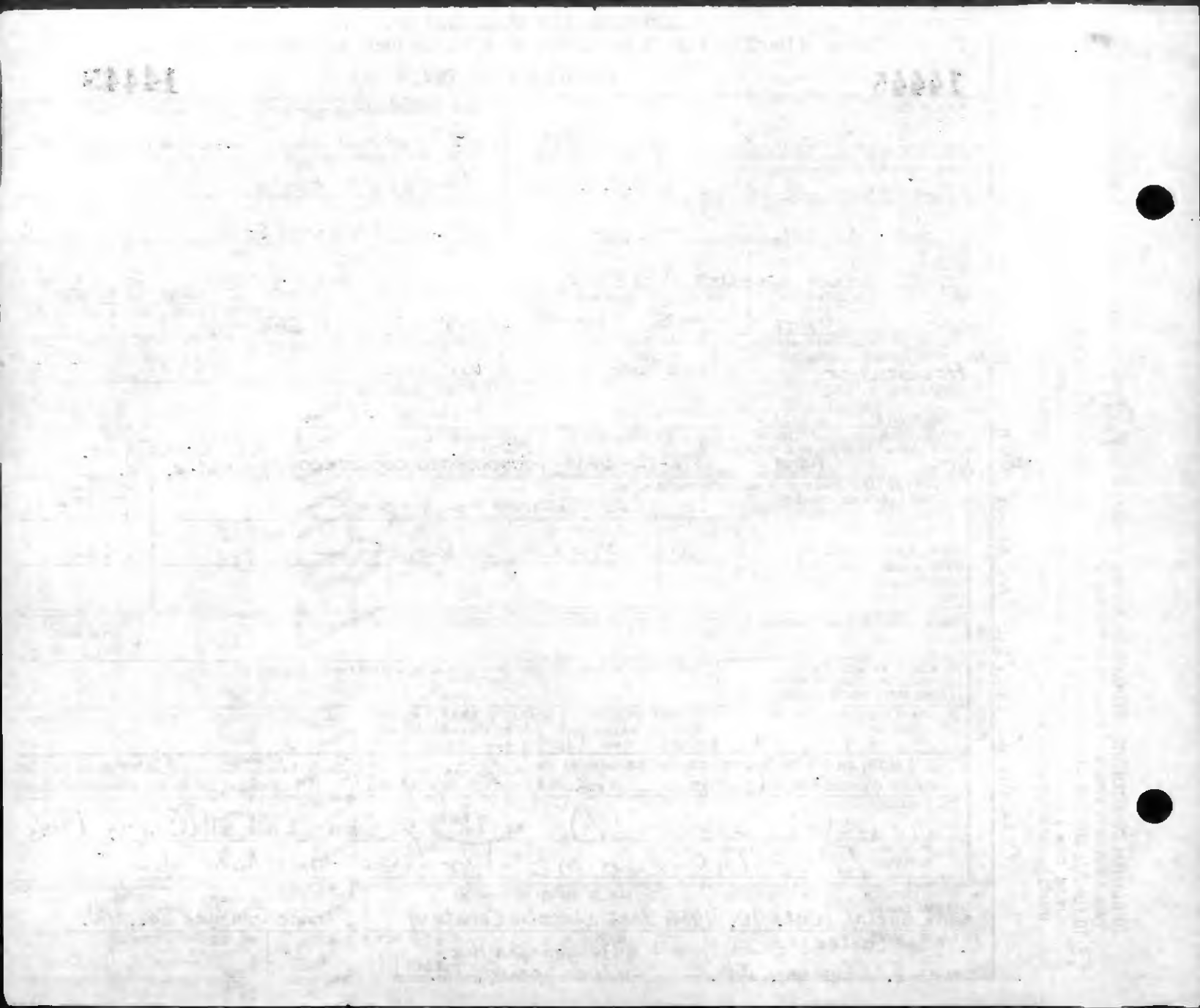
Clerical with Medical Examiner 10/6/66 9:40 PM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11111

11111



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 4 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/66

FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14446

14446

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>2 hr 20 min</u>		d. STREET ADDRESS <u>5200 North Capitol St N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ALROSE</u> First <u>MARSTON</u> Middle <u>RAYMOND</u> Last		4. DATE OF DEATH <u>10-17</u> 19 <u>66</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-27-84</u> 82 yrs
9. AGE (In years last birthday) <u>82</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Store Equipment</u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert M. Raymond</u>		14. MOTHER'S MAIDEN NAME <u>Emma Heck</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-30-7227</u>	
17. INFORMANT <u>George E. Raymond</u> Address <u>313 Lexington Dr. Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Rupture of Aortic Aneurysm.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio Vascular Disease -</u> (c) <u>2 yrs.</u> DUE TO DUE TO DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>10/17/66</u>	
EXAMINER'S NAME (Type) <u>John G. Ball Bethesda, Maryland</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. XX 20, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Switland, Maryland</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas Warner E. Humphrey, Inc.</u>		ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>	
25a. REC'D BY REGISTRAR <u>OCT 20 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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CERTIFICATE OF DEATH

14447

14447

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Key West</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Key West</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>1434 B Reynolds Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>William</b> Last <b>RHEA</b>		4. DATE OF DEATH Month <b>October</b> Day <b>8</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 17, 1966</b>
9. AGE (In years last birthday) yrs. <b>2</b> Months <b>23</b> Days <b>23</b> Hours <b>Min.</b>		10. BIRTHPLACE (County & State, or foreign country) <b>Key West, Florida</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Kennedy J. Rhea</b>		14. MOTHER'S MAIDEN NAME <b>Judith C. Orndorff</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>Key West</b> Address <b>Florida</b> <b>Kennedy J. Rhea, 1434 B Reynolds Street</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>1P/END/WH/ Hypoxia secondary to</b> <b>756-2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Glossoptosis with micrognathia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pierre-Robin Syndrome Multiple congenital anomalies</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Aug. 4</b> , 19 <b>66</b> , to <b>Oct. 8</b> , 19 <b>66</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Oct. 8</b> 19 <b>66</b> and that death occurred at <b>3:20 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Jerry J. Tomasovic</b>		22b. DATE SIGNED <b>Oct. 10, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jerry J. Tomasovic, M.D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Oct. 12, 66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wright Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Findlay, Illinois</b>
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b> <b>7557 Wisconsin Ave., Bethesda, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 13 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14448

## CERTIFICATE OF DEATH

14448

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Howard</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>21 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montg. General Hospital</u>				d. STREET ADDRESS <u>rural</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Augustus</u> <span style="float: right;">Riggs III</span>				<b>4. DATE OF DEATH</b> Month <u>10</u> Day <u>8</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>separated</u>		8. DATE OF BIRTH <u>8/1/85</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Howard County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Augustus Riggs II</u>				14. MOTHER'S MAIDEN NAME <u>Mary Warfield</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Dr. Moomau</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocardial failure</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary sclerosis</u> (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic bronchitis, bronchietasis &amp; emphysema</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1950</u> to <u>Oct 8, 1966</u> that (I) (we) last saw the deceased alive on <u>Oct 8, 1966</u> , and that death occurred at <u>1 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles S. Whitaker</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/9/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES S WHITAKER, MD</u>				22d. ADDRESS <u>CLARKSVILLE, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-11-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAK Grove Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Howard Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Haight</u>				ADDRESS <u>Lykensville, Md.</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
				25b. REGISTRAR'S SIGNATURE		DATE <u>OCT 12 1966</u>	

20111

WPA-DO NOT REPRODUCE

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14449

CERTIFICATE OF DEATH

14449

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pate Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cherry Chase Nursing &amp; Convalescent Center</u>		d. STREET ADDRESS <u>7210 Maple Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>D.</u> Last <u>Roberts</u>		4. DATE OF DEATH Month <u>October</u> Day <u>24</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>18 June 1873</u>
9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Army (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BRIG Gen.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>South Dakota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.P.</u>	
13. FATHER'S NAME <u>BRIG Gen 389. Roberts</u>		14. MOTHER'S MAIDEN NAME <u>NANETTE R. DUVAL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes.</u> (If yes give war or dates of service) <u>1897-1937</u>		16. SOCIAL SECURITY NO. <u>  -  -  </u>	
17. INFORMANT <u>Col. Thomas D. Roberts</u>		Address <u>Beth. Md. 5480 Wis. Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4201 DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 min.</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 1</u> , 19 <u>65</u> , to <u>Oct 24</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Aug 8</u> , 19 <u>66</u> , and that death occurred at <u>8:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Simon C. Weiner</u>		22b. DATE SIGNED <u>Oct 24, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Simon Weiner</u>		22d. ADDRESS <u>8201-16 St. Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/27/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington Va.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>OCT 27 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

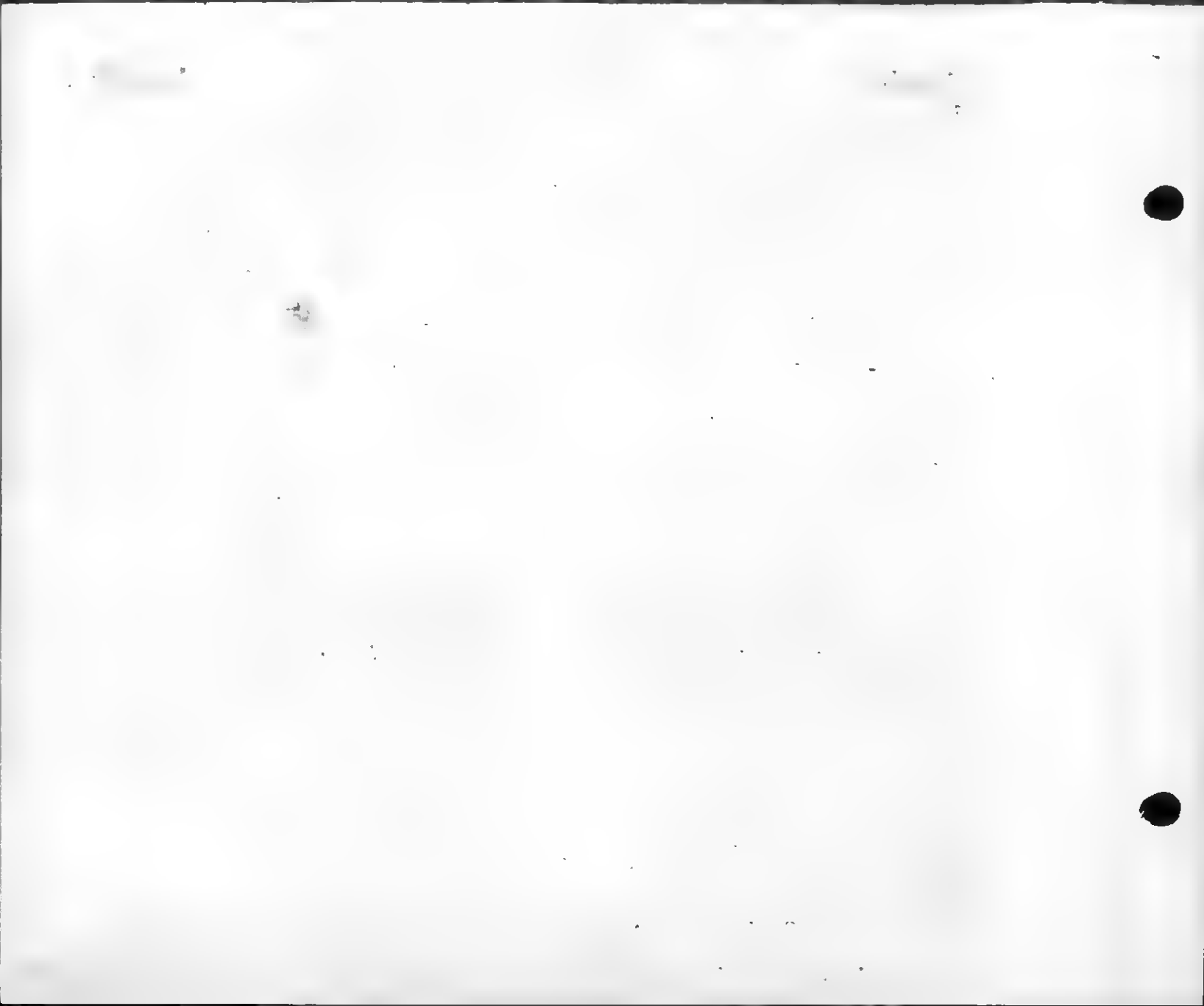
14450

14450

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>DISTRICT OF COLUMBIA</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		d. STREET ADDRESS <u>4401 BRANDYWINE, N.W.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>WINIFRED B. ROBEY</u>		4 DATE OF DEATH Month Day Year <u>OCT 21 1966</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-29-89</u>
9 AGE (in years, months, days) <u>77</u> yrs		10 IF UNDER 1 YEAR Months Days Hours Min. <u>0 22</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Sect. U.S. Govt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Illinois</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fritz C. Barnum</u>		14. MOTHER'S MAIDEN NAME <u>Ida ?</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>?</u>	
17 INFORMANT <u>Mrs. Audrey Derrick - Step-Daughter</u>		Address <u>5000</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Renal Insufficiency with terminal uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Nephrosclerosis, advanced.</u> (c) <u>Arteriosclerosis, general, with Hypertension 10 yrs +</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1) Diabetes Mellitus 2) Myocardial decomp. chronic 3) CVA</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>OCT 21, 1966</u> , that (I) (we) last saw the deceased alive on <u>OCT 21</u> 19 <u>66</u> , and that death occurred at <u>10:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Stewart Clapp M.D.</u>		22b. DATE SIGNED <u>OCT 21 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp M.D.</u>		22d. ADDRESS <u>4740 Chevy Chase Dr. Chevy Chase Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-25-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Bethesda, Maryland</u>	
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>OCT 20 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

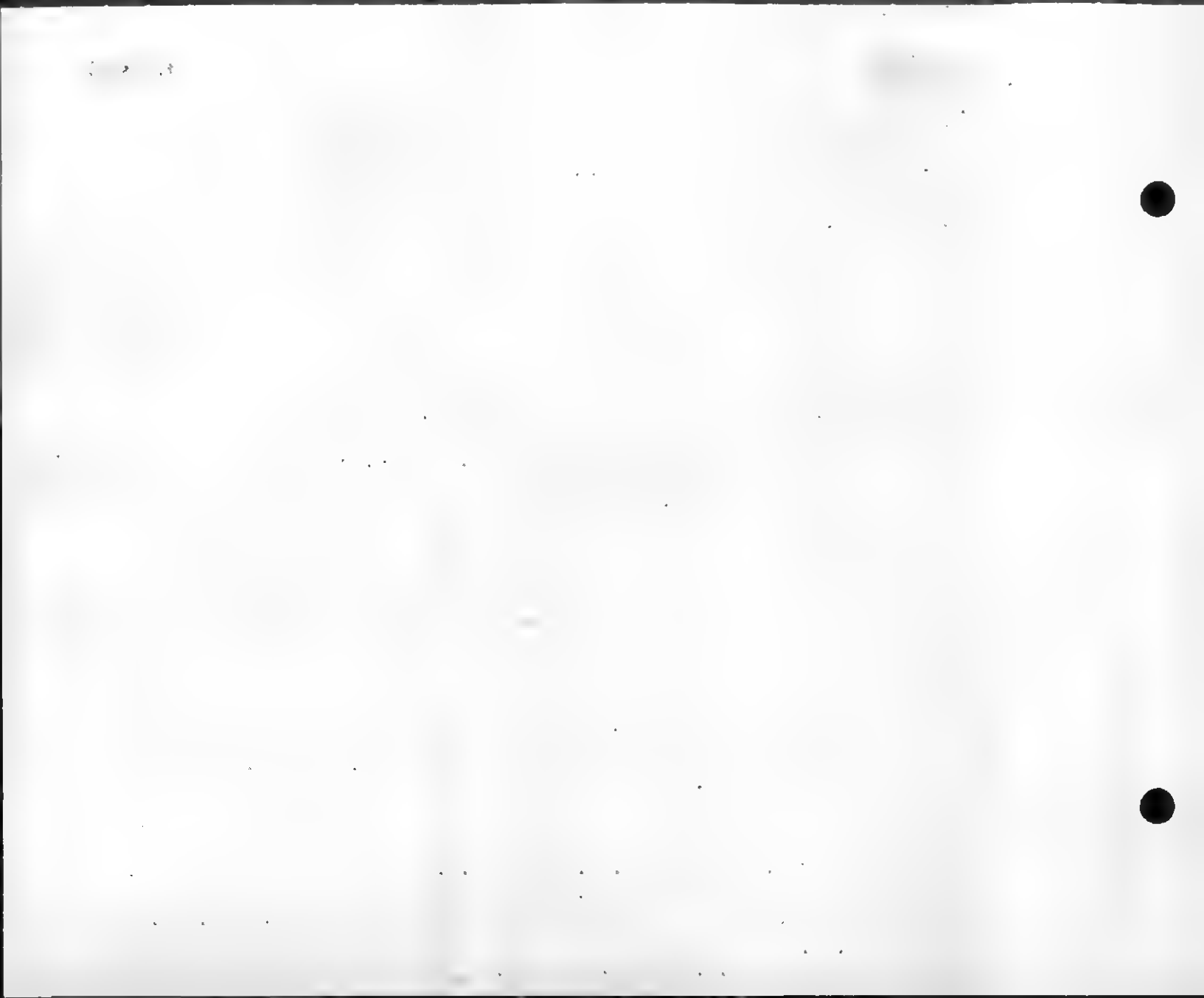
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14451

CERTIFICATE OF DEATH

14451

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Argentina</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>			c. LENGTH OF STAY IN lb <b>42 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Buenos Aires</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital</b>				d. STREET ADDRESS <b>Juramento 1733</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Celia</b> First <b>Cristina</b> Middle <b>ROMERO</b> Last				4 DATE OF DEATH Month <b>October</b> Day <b>3</b> Year <b>19 66</b>			
5 SEX <b>Female</b>		6 COLOR OR RACE <b>Caucasian</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>May 7, 1951</b>	
9 AGE (in years last birthday) yrs. <b>15</b>		IF UNDER 1 YEAR Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min <b>15</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Argentina</b>		12 CITIZEN OF WHAT COUNTRY? <b>Argentina</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		13 FATHER'S NAME <b>Rene Arnaldo Romero</b>	
14 MOTHER'S MAIDEN NAME <b>Celia Corina Madina</b>				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>N/A</b> (If yes give war or dates of service)			
16 SOCIAL SECURITY NO. <b>N/A</b>				17. INFORMANT Address <b>Argentina</b> <b>Rene A. Romero, Juramento 1733, Buenos Aires</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphosarcoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>(x)</del> (this hospital) attended the deceased from <b>Aug. 23</b> , 19 <b>66</b> , to <b>Oct. 3</b> , 19 <b>66</b> , that <del>(x)</del> (we) last saw the deceased alive on <b>Oct. 3</b> , 19 <b>66</b> , and that death occurred at <b>3:10 A.M.</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Peter T. Kirchner</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Oct. 3, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Peter T. Kirchner, M. D.</b>				22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 11, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cementerio del Oeste</b>		23d. LOCATION (City or Town) (County) (State) <b>Chacarita, BS. AS. Argentina</b>	
24. FUNERAL DIRECTOR <b>W. W. Chambers Co.</b> ADDRESS <b>1400 Chapin Street, N.W. Washington, D.C.</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 5 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14452

## CERTIFICATE OF DEATH

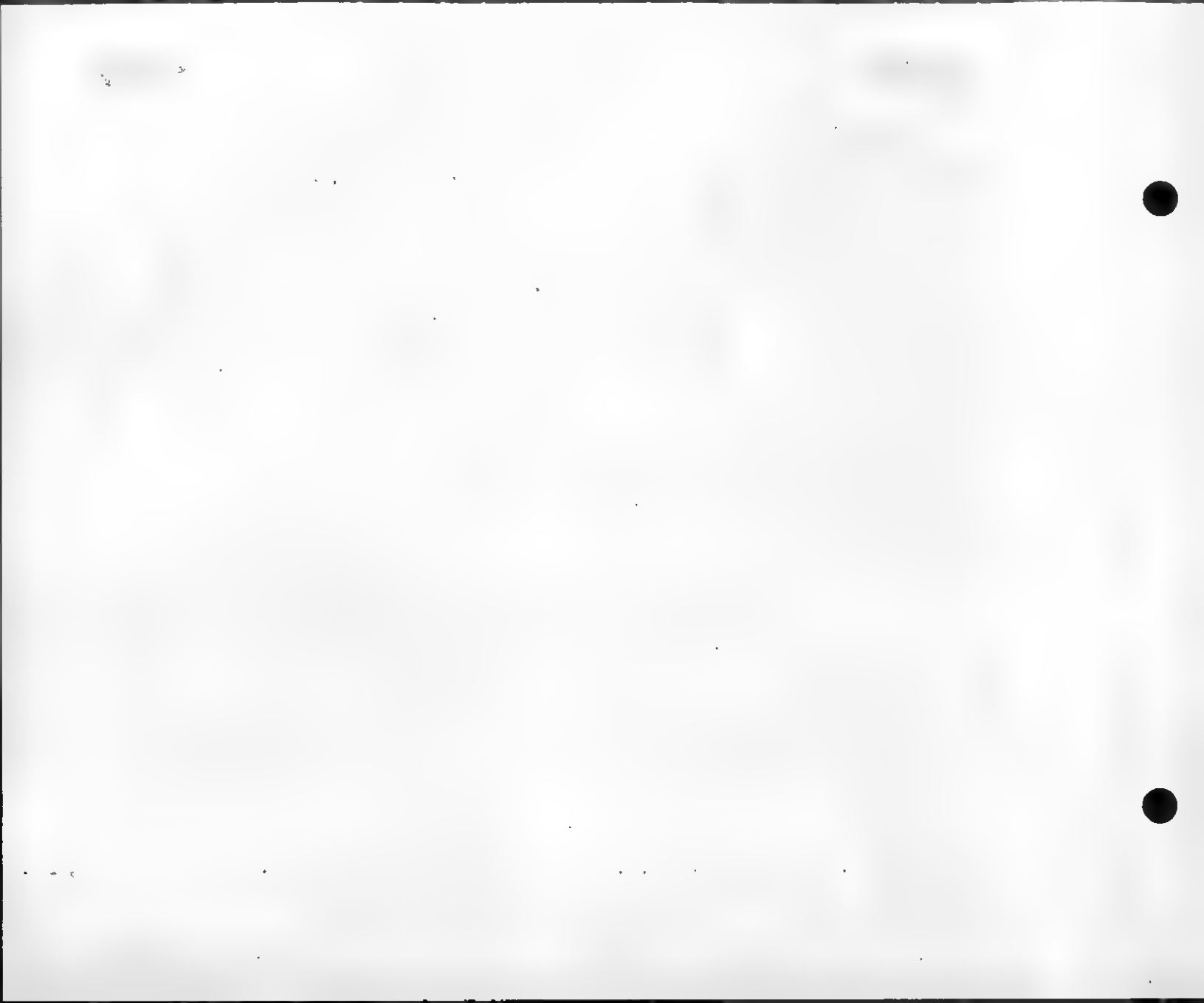
14452

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chary Chase</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>8568 Freyman Dr.</u>	
3 NAME OF DECEASED (Type or print) <u>Deborah Ann Rosen</u>		4 DATE OF DEATH <u>10</u> Month <u>27</u> Day <u>19</u> Year <u>66</u>	
5. SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/23/49</u>
9 AGE (In years last birthday) <u>16</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Welch-West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Irving Rosen</u>		14. MOTHER'S MAIDEN NAME <u>Annabelle Salle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Father-Irving Rosen - as above</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Mumps meningoencephalitis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>27 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Disseminated lupus erythematosus</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>60</u> , to <u>Oct 27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>OCT 26 1966</u> , and that death occurred at <u>6:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>G. Lennard Gold</u>		22b. DATE SIGNED <u>10/27/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Lennard Gold, M.D.</u>		22d. ADDRESS <u>8641 Colesville Rd., Silver Spring, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10-30-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON HEBREW CONC.</u>	23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON - DC</u>
24 FUNERAL DIRECTOR <u>BERNARD DANZANSKY &amp; SONS - WASHINGTON DC</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 28 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

Cleared by Dr. Keep. Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14453

## CERTIFICATE OF DEATH

14453

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u> c. LENGTH OF STAY IN 15 <u>1 hr. 47 min.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Naval Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>14105 Heathfield Court</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Baby Girl ROSIE</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>OCT. 16 19 66</u>									
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Cauc</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Oct. 16, 1966</u>		<b>9. AGE</b> (In years last birthday) yrs <u>1</u>		<b>10. FUNERAL</b> YEAR MONTHS DAYS HOURS <u>1 47</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>N/A</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>N/A</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Montgomery, Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Ronald D. Rosie</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Mildred Thomson</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>N/A</u>				<b>16. SOCIAL SECURITY NO.</b> <u>N/A</u>		<b>17. INFORMANT</b> <u>Rockville</u> Address <u>Md.</u> <u>Ronald D. Rosie, 14105 Heathfield Court</u>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b) and (c)) <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Massive subdural hemorrhage</u> <u>7600</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } <b>(b)</b> _____ DUE TO <b>(c)</b> _____												<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that (s) (this hospital) attended the deceased from</b> <u>Oct. 16</u> , 19 <u>66</u> , to <u>Oct. 16</u> , 19 <u>66</u> , that (s) (we) last saw the deceased alive on <u>Oct. 16</u> , 19 <u>66</u> , and that death occurred at <u>1231 M.</u> from causes and on the date stated above.													
<b>22a. SIGNATURE</b> <u>T. E. Kelly</u>						<b>22b. DATE SIGNED</b> <u>Oct. 19, 1966</u>				<b>22c. PHYSICIAN'S NAME (Type)</b> <u>T. E. KELLY, M.D.</u>			
<b>22d. ADDRESS</b> <u>Naval Hospital, Bethesda, Md.</u>													
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>10-20-66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u>				<b>23d. LOCATION (City or Town)</b> (County) (State) <u>Arlington, Va.</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Robert A. Pumphrey</u> ADDRESS <u>Md.</u> <u>Funeral Home, 7557 Wisconsin Ave. Bethesda, /</u>						<b>25a. REC'D BY REGISTRAR</b> <u>DATE OCT 21 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14454

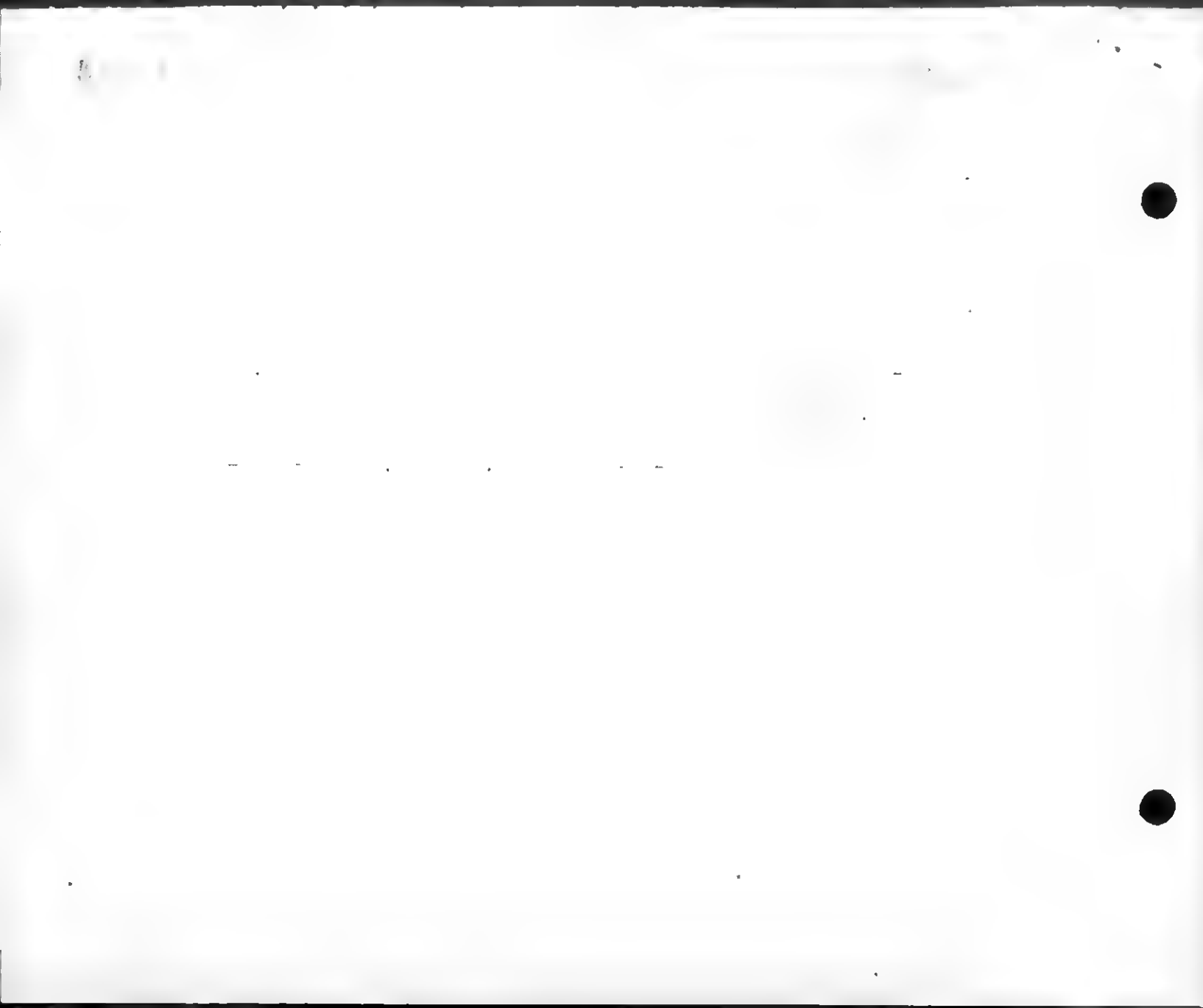
14454

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Add pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY in lb <b>6 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8300 Bradley Boulevard</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Earle</b> Last <b>ROYER</b>		4. DATE OF DEATH Month <b>October</b> Day <b>5</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 31, 1897</b>
9. AGE (in years last birthday) <b>69</b>		10. FUNDING YEAR Months <b>4</b> Days <b>4</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auditor-Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Walter S. Royer</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Pate</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO <b>577-20-5849</b>	
17. INFORMANT <b>Mrs. Jean G. Royer-Wife-Sameas</b>		Address <b>Item #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Insufficiency Acute.</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cardio Vascular Disease.</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b></b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John G. Ball</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JOHN G. BALL</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>Bethesda, Md.</b>	
22. DATE SIGNED <b>October 6, 1966</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>10/6/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City or town) (County) (State) <b>Suitland Maryland</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
25a. REC'D BY REGISTRAR <b>OCT 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. (See Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.)

VR A15ME (5)  
6M 1/66

Items 18&21 Film 382 11-2 **MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14455

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14455

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c LENGTH OF STAY in lb <b>4 days/19hr/15m</b>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>		d. STREET ADDRESS <b>4410 Van Buren St.</b>	
3 NAME OF DECEASED (Type or print) First <b>Dorothy</b> Middle <b>Elizabeth</b> Last <b>Sadorus</b>		4 DATE OF DEATH Month <b>October</b> Day <b>31</b> Year <b>1966</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>March 23, 1916</b>
9 AGE (In years last birthday) yrs <b>50</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11 BIRTHPLACE (State or foreign country) <b>Illinois</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Roy Moon</b>		14 MOTHER'S MAIDEN NAME <b>Roxie Mattix</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b>Unk</b>	
17 INFORMANT Address <b>Hospital Records, Washington San &amp; Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Massive metastatic hepatic cancer with</b> <b>156.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>marked inferior vena cava compression and shock</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			9 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Reap</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Belden R. Reap, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 3, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Colmar Manor, Pro Geo Md.</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>NOV 7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

22. DATE SIGNED  
**10/31/1966**



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

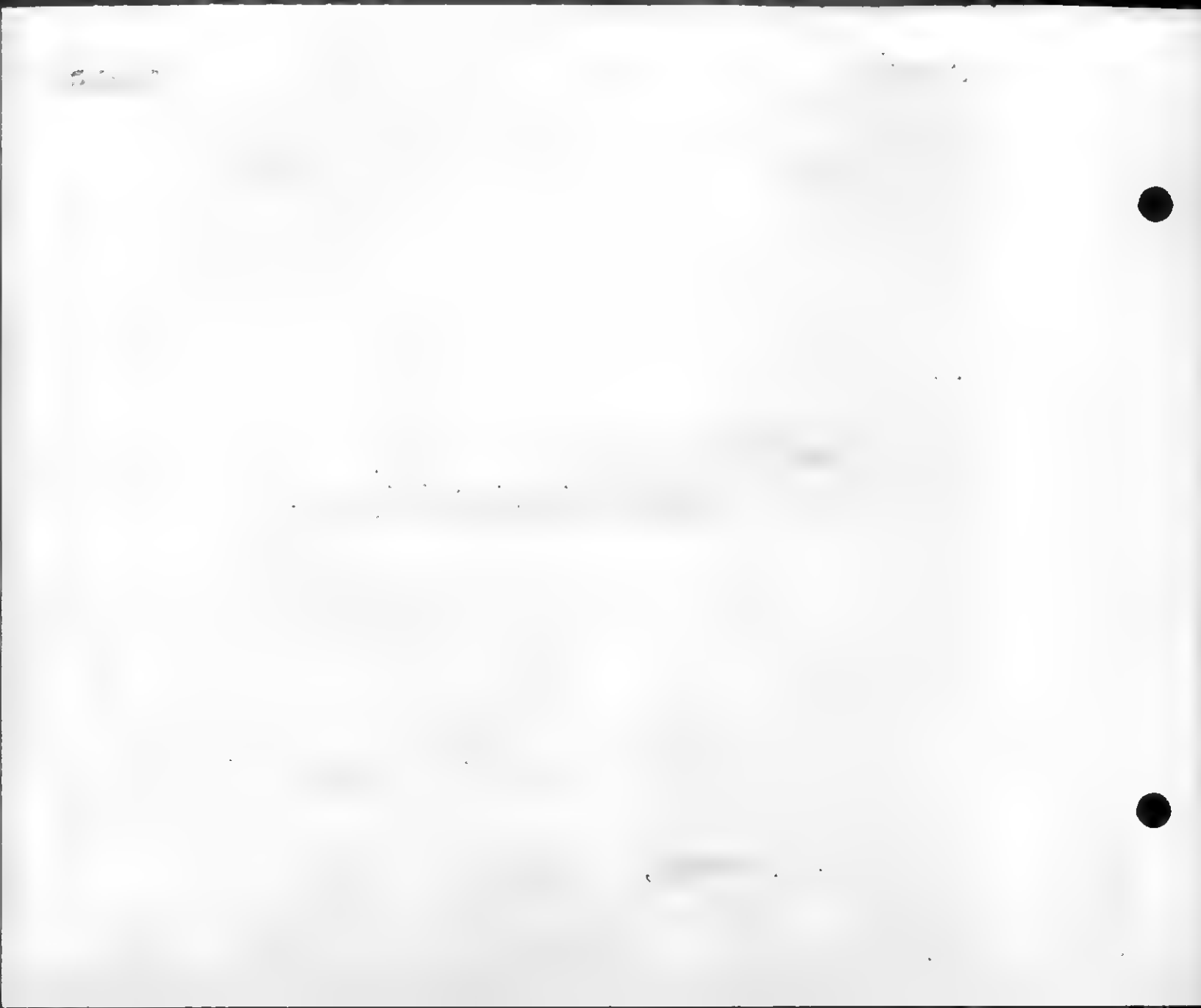
14456

## CERTIFICATE OF DEATH

14456

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) ✓ a. STATE <b>New York</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb <b>27 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Kurt</b> Middle <b>TH</b> Last <b>SCHWARTING</b>		4. DATE OF DEATH Month <b>October</b> Day <b>28</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8 Jan 1940</b>
9. AGE (In years last birthday) <b>26</b> yrs		10. IF UNDER 1 YEAR Months <b>26</b> Days <b>26</b> Hours <b>26</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Rockville Center, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US.</b>	
13. FATHER'S NAME <b>John Russell SCHWARTING</b>		14. MOTHER'S MAIDEN NAME <b>Ruth STEVENSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 9 Dec 1958</b>		16. SOCIAL SECURITY NO. <b>125-32-6266</b>	
17. INFORMANT <b>Mrs. Susan R. SCHWARTING</b>		Address <b>9517 Cable Drive Kensington, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per box (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4222</b> DUE TO <b>Acute Interstitial Myocarditis</b> <b>Extensive Myocardial fibrosis, chronic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1 Oct</b> , 19 <b>66</b> to <b>28 Oct</b> , 19 <b>66</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>28 Oct</b> , 19 <b>66</b> , and that death occurred at <b>655 A</b> M, from causes and on the date stated above			
22a. SIGNATURE <b>Jack E. Zimmerman</b> M.D.		22b. DATE SIGNED <b>28 Oct 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jack E. ZIMMERMAN, LT MC USN</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>11/2/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NOTIC</b>	23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON, VA</b>
24. FUNERAL DIRECTOR <b>W.W. Chambers Co. Inc</b>		25a. REC'D BY REGISTRAR <b>1400 Chapin St NW Wash. DC</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>NOV 2 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14457		14457	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15810 Bradford Rd.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>10 yrs.</u>		d. STREET ADDRESS <u>14 Washington St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bradford Rest Home, Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cornelia</u> Middle <u>Scott</u> Last <u>Scott</u>		4. DATE OF DEATH Month <u>10</u> Day <u>30</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 3, 1882</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Annie Brice</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Cornelia Scott, Daughter</u>		Address <u>506 Bickford Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Arterio sclerosis</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that (I) (this hospital) attended the deceased from <u>1-26</u> , 19 <u>63</u> , to <u>10-30</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>10-30</u> , 19 <u>66</u> , and that death occurred at <u>10:2</u> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Oliver E. Jackson</u>		22b. DATE SIGNED <u>10-30-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>  </u>		22d. ADDRESS <u>202 Martin Ln., Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11/2/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>	23d. LOCATION (City, town or county) (State) <u>Rockville Md.</u>
24. FUNERAL DIRECTOR <u>Robert L. Suorden</u>		25a. REC'D BY REGISTRAR <u>  </u>	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>NOV 2 1966</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 14 Film 3-52 11/7/66 mn

## CERTIFICATE OF DEATH

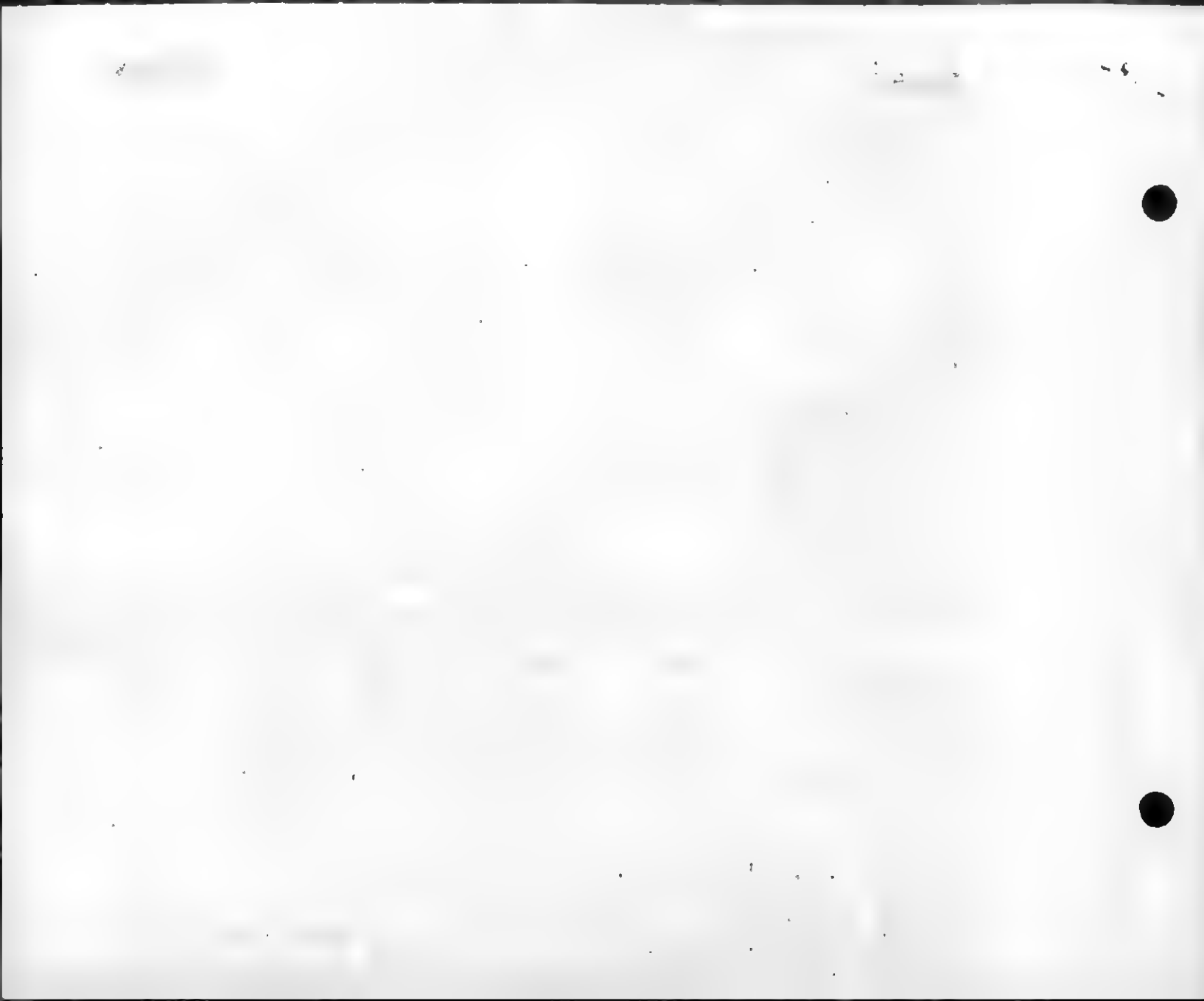
14458

14458

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b></b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>3405 Dunnington Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Emmett</b> Last <b>SHEA, JR.</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>26</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 4, 1912</b>
9. AGE (In years last birthday) yrs <b>54</b>		10. UNDER 1 YEAR Months Days Hours Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (Country & State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas E. Shea</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes 1943-1959</b>		16. SOCIAL SECURITY NO <b></b>	
17. INFORMANT <b>Mrs. Thomas E. Shea, Jr., 3405 Dunnington Rd., Beltsville Md.</b>		Address <b></b>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b></b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b></b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	20f. (City or town) (County) (State) <b></b>
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 20, 1966</b> , to <b>Oct. 26, 1966</b> that (I) (we) last saw the deceased alive on <b>Oct. 26, 1966</b> , and that death occurred at <b>6:47 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>27 Oct. 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. H. O'CONNELL, M. D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10-28-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>Robert H. Humphrey</b> ADDRESS <b>Md.</b>		25a. REC'D BY REGISTRAR <b></b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
Funeral Home, <b>4557 Wisconsin Ave., Bethesda, /</b>		DATE <b>NOV 1 1966</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

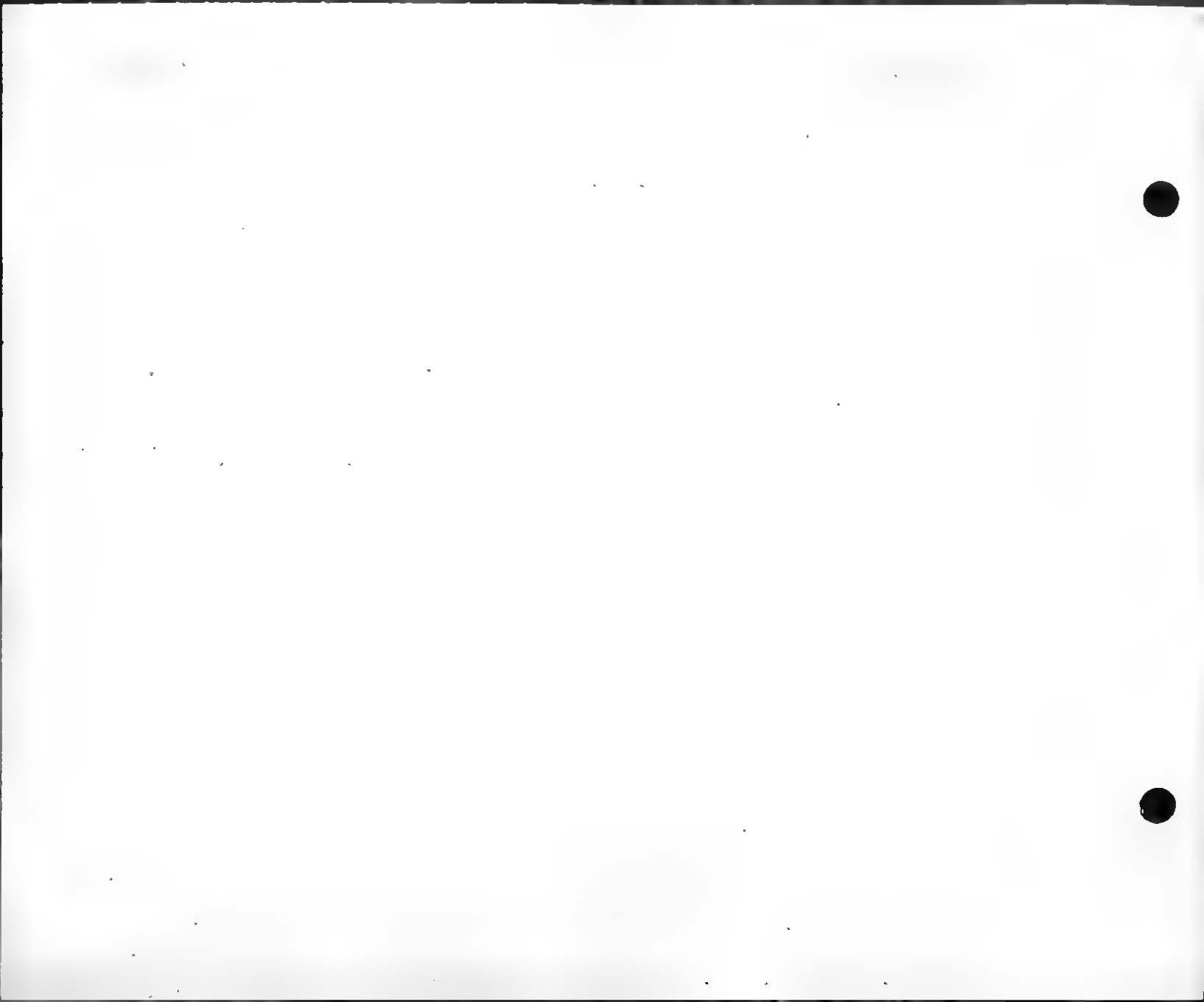
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14459

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14459

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c LENGTH OF STAY IN 1b <u>D.O.A.</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>			d STREET ADDRESS <u>4203 Roundhill Rd.</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Paul</u> <u>Edward</u> <u>Shelley</u>			4 DATE OF DEATH Month Day Year <u>Oct</u> <u>9</u> <u>19 66</u>		
5 SEX <u>M</u>	6 COLOR OR RACE <u>Cau</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5/19/24</u>		9 AGE (In years last birthday) <u>42</u> yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Technician</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Vitro Lab. Government</u>		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13 FATHER'S NAME <u>Raymond Shelley</u>			14 MOTHER'S MAIDEN NAME <u>Jessie M. Crenshaw</u>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>U.S. Navy</u>		16 SOCIAL SECURITY NO <u>284 26 0359</u>		17 INFORMANT <u>4203 Roundhill Rd., S.S., Md.</u> <u>Mrs. Jeanette Shelley, wife</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary Artery Heart Disease</u> (c)					INTERVAL BETWEEN ONSET AND DEATH
PART OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>OCT. 11 1966</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Oct. 14, 1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Milledgeville Cemetery</u>	23d LOCATION (City or town)	(County)	(State) <u>Milledgeville, Ohio</u>
24 FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Avenue</u> <u>Silver Spring, Md.</u>		25a REC'D BY REGISTRAR DATE <u>OCT 14 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

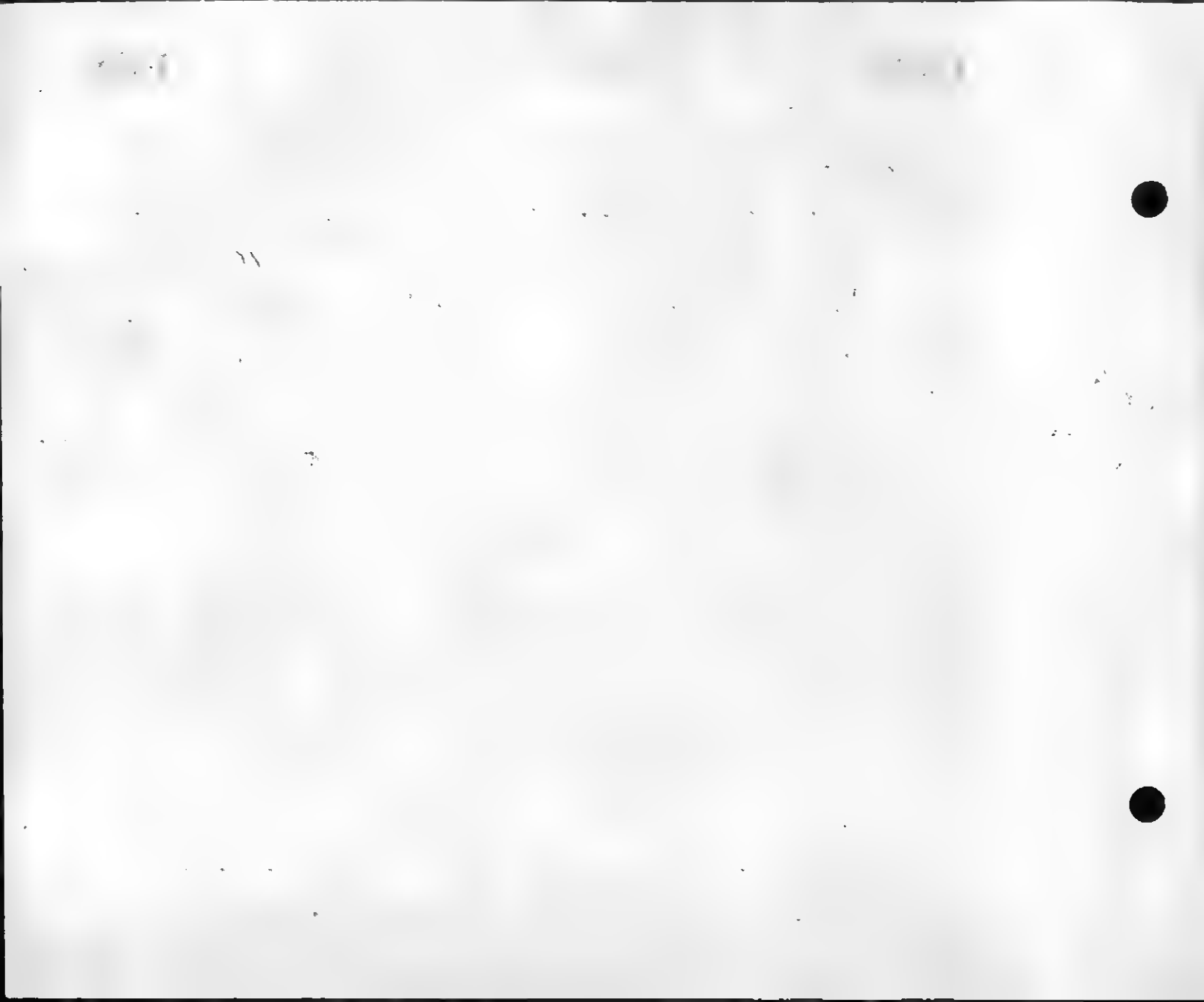


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14460 CERTIFICATE OF DEATH 14460

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> c. LENGTH OF STAY IN 1b <u>10 Mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>University Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> d. STREET ADDRESS <u>10207 Ridgemoor Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First <u>XXXXXX</u> Middle <u>Louis</u> Last <u>Shipley</u>		4. DATE OF DEATH <u>10</u> Month <u>9</u> Day <u>19</u> Year <u>66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Caus.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/24/1889</u>
9. AGE (in years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>18</u> Hours <u>15</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bank Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH LLOYD SHIPLEY</u>		14. MOTHER'S MAIDEN NAME <u>SANNIE STEFFE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>ARMY</u> (If yes give war or dates of service) <u>WORLD WAR I</u>		16. SOCIAL SECURITY NO. <u>577-10-2194</u>	
17. INFORMANT <u>Miss Eleanor L. Dankmeyer</u>		Address <u>10203 Ridgemoor Dr., S.S., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>7</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4-5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> to <u>9 Oct</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8 Oct</u> , 19 <u>66</u> , and that death occurred at <u>7:30 A</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>William D. And</u>		22b. DATE SIGNED <u>10/9/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>William D. And</u>		22d. ADDRESS <u>9006 Colesville Rd., S.S., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 12, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>
24. FUNERAL DIRECTOR <u>John B. Thomas</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>2434 GEORGIAN</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

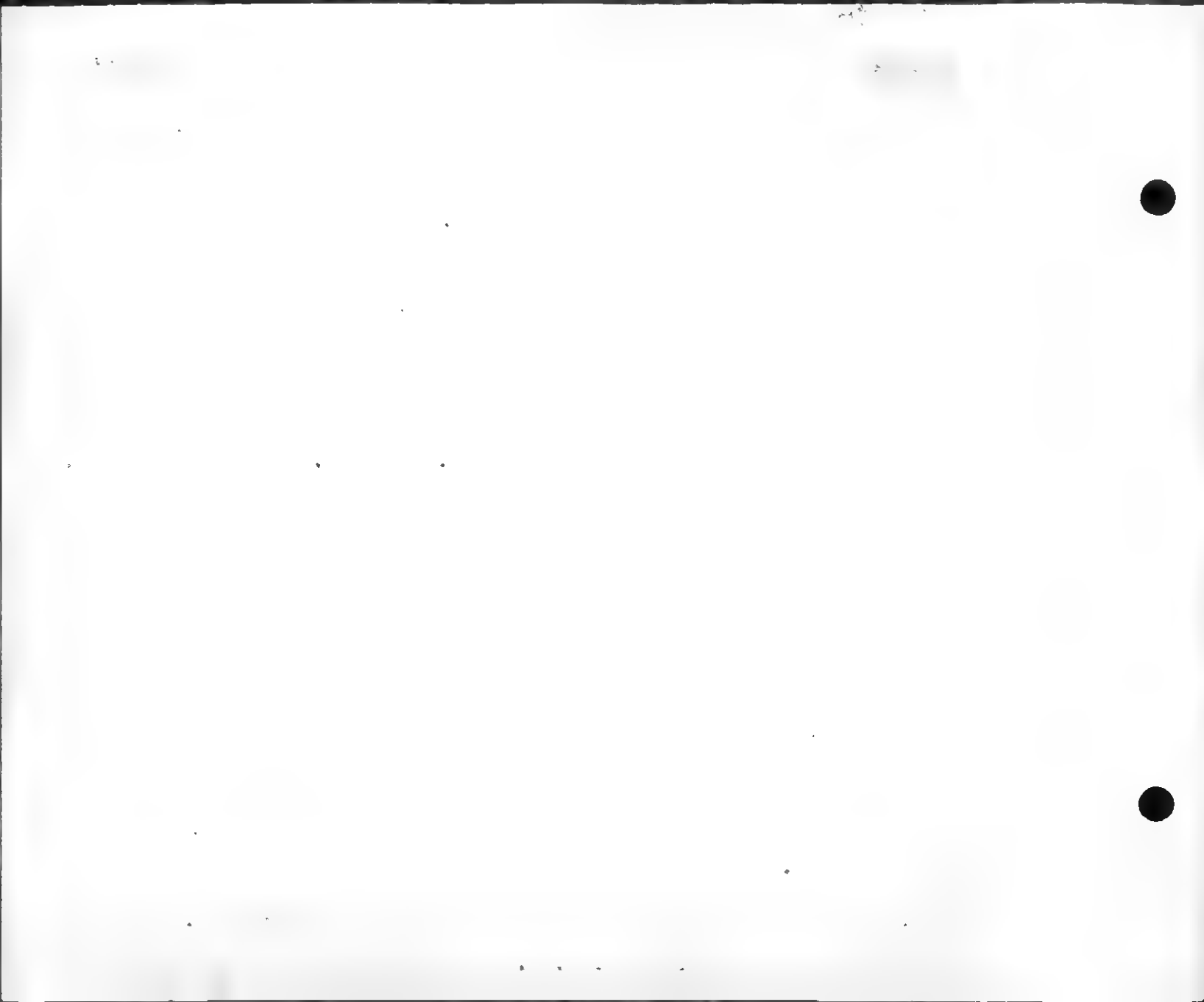
Item #3 Film #3292 11/1/56 pc

14461

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14461

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Montgomery</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R. Rockville</u>		c LENGTH OF STAY N Ib <u>15 min.</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural. Pikesville.</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>13700 Pines Meeting House Rd.</u>				d STREET ADDRESS <u>Northern Farms.</u>		e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Bernard</u> Middle <u>Norton</u> Last <u>Siegel</u>				4 DATE OF DEATH Month <u>Oct.</u> Day <u>22</u> Year <u>1966</u>			
5 SEX <u>M.</u>		6 COLOR OR RACE <u>W</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>March 20, 1910</u>	
9 AGE (In years last birthday) <u>56</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11 BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13 FATHER'S NAME <u>LEWIS SIEGEL</u>				14 MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>  </u>		17 INFORMANT <u>MRS. LAVINE C. SIEGEL</u> Address <u>POOLSVILLE, MD</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Laceration + Maceration of Brain.</u> X DUE TO (b) <u>Gun Shot Wound of Head -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (c) <u>  </u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden.</u> <u>Sudden.</u>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Shot - Self - with .38 cal. Revolver - Right Temple.</u>					
20c TIME OF INJURY Month, Day, Year Hour <u>12:15</u> pm <u>10/22/1966</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f (City or town) (County) (State) <u>Rural Rockville Mont. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/22/66</u>			
				Address (Street, city, town, or county) <u>  </u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>10/24/66</u>		23c NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		23d LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24 FUNERAL DIRECTOR <u>Joseph Gawler Sons</u> Address <u>Washington, D. C.</u>				25a REC'D BY REGISTRAR DATE <u>OCT 27 1966</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

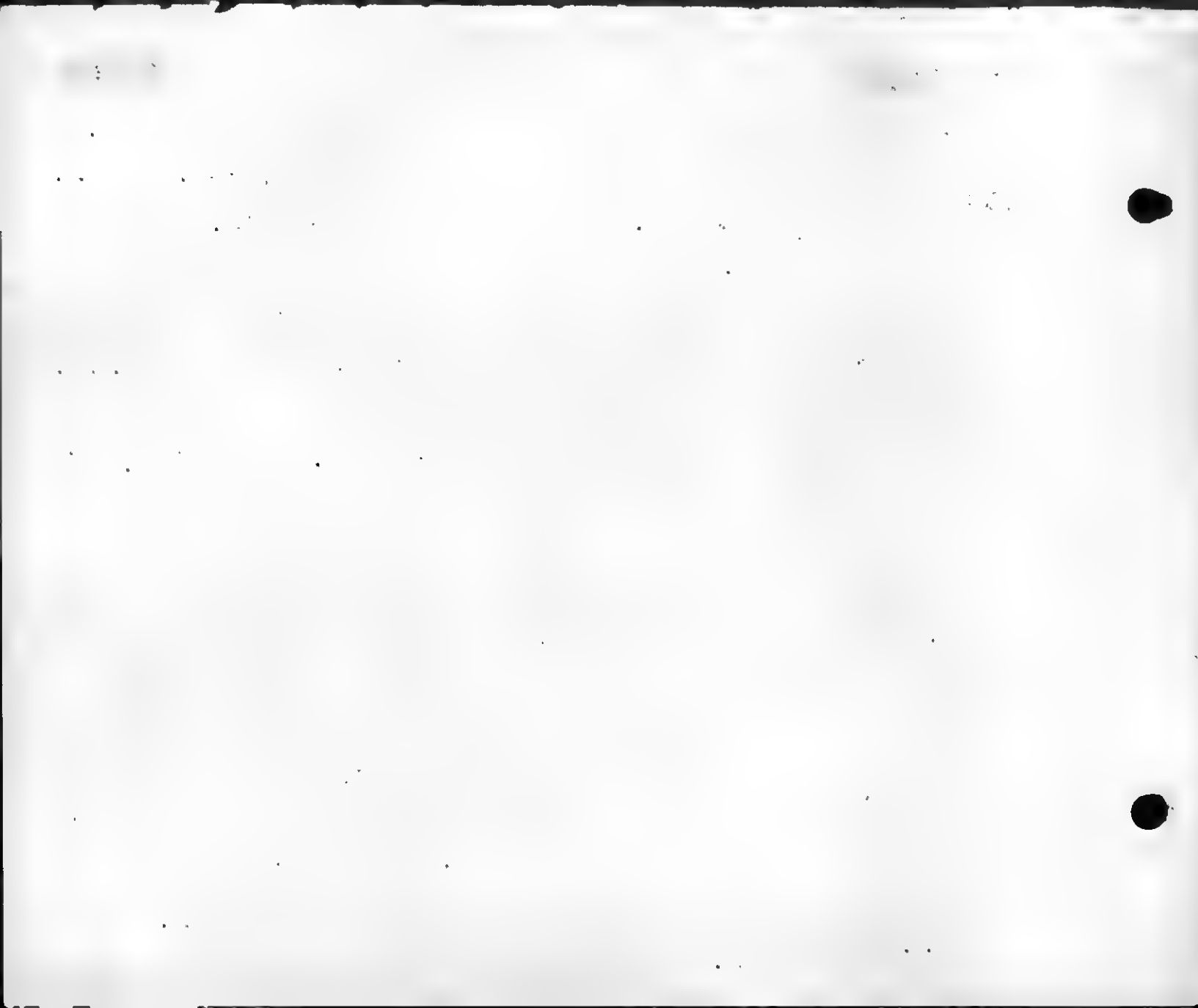


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14462 CERTIFICATE OF DEATH 14462

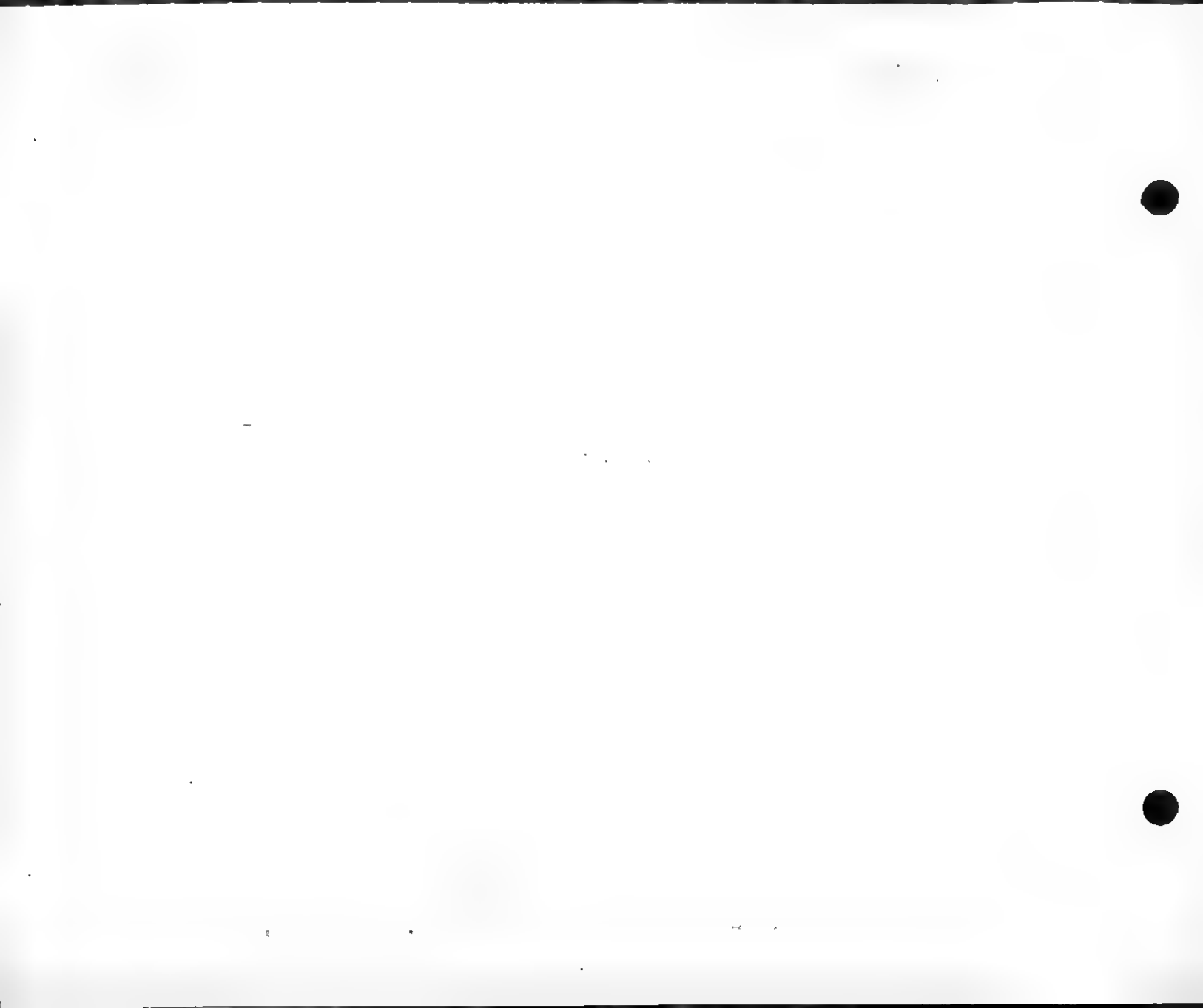
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Shirlington</i> b. COUNTY <i>D.C.</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Beltsville</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>717 Quackenbos St. N.W. Wash. D.C.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Henry H. Simons</i>		4. DATE OF DEATH Month <i>10</i> Day <i>15</i> Year <i>1966</i>	
5. SEX <i>F</i>	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) yrs. <i>70</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		11b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
12. BIRTHPLACE (County & State, or foreign country) <i>Wash. D.C.</i>		13. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
14. FATHER'S NAME <i>Powell</i>		15. MOTHER'S MAIDEN NAME <i>Sarah S. Hoch</i>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)		17. SOCIAL SECURITY NO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. OATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>generalized arteriosclerosis</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>a.m.</i> <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>JUNE</i> , 19 <i>66</i> , to <i>Oct 15</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Oct 15</i> , 19 <i>66</i> , and that death occurred at <i>9:45</i> P.M., from the causes and on the date stated above.			
22a. SIGNATURE <i>D.L. Bucy</i>		22b. DATE SIGNED <i>10-15-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>D.L. Bucy</i>		22d. ADDRESS <i>809 VEIR'S Mill Rd Rockville</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>10/17</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>W. &amp; H. Shuterbaum</i>		23d. LOCATION (City, town or county) (State) <i>Shirlington D.C.</i>	
24. FUNERAL DIRECTOR <i>W. &amp; H. Shuterbaum</i>		25a. REC'D BY REGISTRAR <i>W. &amp; H. Shuterbaum</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>OCT 18 1966</i>	



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Items 18&21 Film 382 11-MARYLAND-STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
14463		MEDICAL EXAMINER'S CERTIFICATE OF DEATH				14463				
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>					
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Taroma Park, Md.</u>			c. LENGTH OF STAY IN 1b <u>12 1/2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nyattsville</u>					
d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>					d. STREET ADDRESS <u>2812 Charleston Place</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Coy</u> Middle <u>Dell</u> Last <u>Sims</u>					4. DATE OF DEATH Month <u>10</u> - Day <u>12</u> - Year <u>1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-2-86</u>		9. AGE (In years last birthday) <u>79</u> yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Levi Christenberry</u>					14. MOTHER'S MAIDEN NAME <u>Margaret</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>			16. SOCIAL SECURITY NO. <u>310-38-3307</u>		17. INFORMANT <u>Hospital Chart</u>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thrombosis, left;</u> <u>300.4</u> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED		
EXAMINER'S NAME (Type) <u>BELDEN R. REAP</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>10-12-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Walnut Hill Cem.</u>		23d. LOCATION (City or town) (County) (State) <u>Odon, Indiana</u>	
24. FUNERAL DIRECTOR <u>Mr. S. H. Hines</u>					ADDRESS <u>2901-14th</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14464

## CERTIFICATE OF DEATH

14464

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> c. LENGTH OF STAY IN 1b <u>8 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brook Grove Foundation</u>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Wheeler, W. Va.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethany Pike</u> d. STREET ADDRESS <u>Bethany Pike</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Reba</u> First <u>Graham</u> Middle <u>Slawson</u> Last		4. DATE OF DEATH <u>October 25</u> Month <u>1966</u> Day <u>19</u> Year		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 23 1876</u>		9. AGE (In years last birthday) <u>90</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John N. Graham</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Varnet</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>-</u> Address <u>-</u>		18. CAUSE OF DEATH (Enter only one cause for line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO PNEUMONIA</u> DUE TO (b) <u>CACHEXIA + INANITION</u> DUE TO (c) <u>ARTERIO SCLEROTIC C.V. DISEASE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BRAIN SYNDROME - ARTERIO SCLEROTIC</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>10/25</u> p.m. <u>10/25</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>64 10/25</u>		20f. (City or town) <u>1/13</u> (County) <u>1966</u> (State) <u>10/25</u>		21. I certify that (1) (this hospital) attended the deceased from <u>1/13</u> to <u>10/25</u> , 19 <u>66</u> that (1) (we) last saw the deceased alive on <u>10/24</u> , 19 <u>66</u> , and that death occurred at <u>3:20</u> P.M. from the causes and on the date stated above.	
22a. SIGNATURE <u>Donald R. Lewis MD</u>		22b. DATE SIGNED <u>10/25/66</u>		22c. PHYSICIAN'S NAME (Type) <u>DONALD R. LEWIS MD</u>		22d. ADDRESS <u>SILVER SPRING, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>10-27-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillside Cemetery</u>		23d. LOCATION (City, town or county) <u>Middletown, N.Y.</u> (State) <u>-</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gayler &amp; Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>OCT 31 1966</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and return them to the funeral director. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

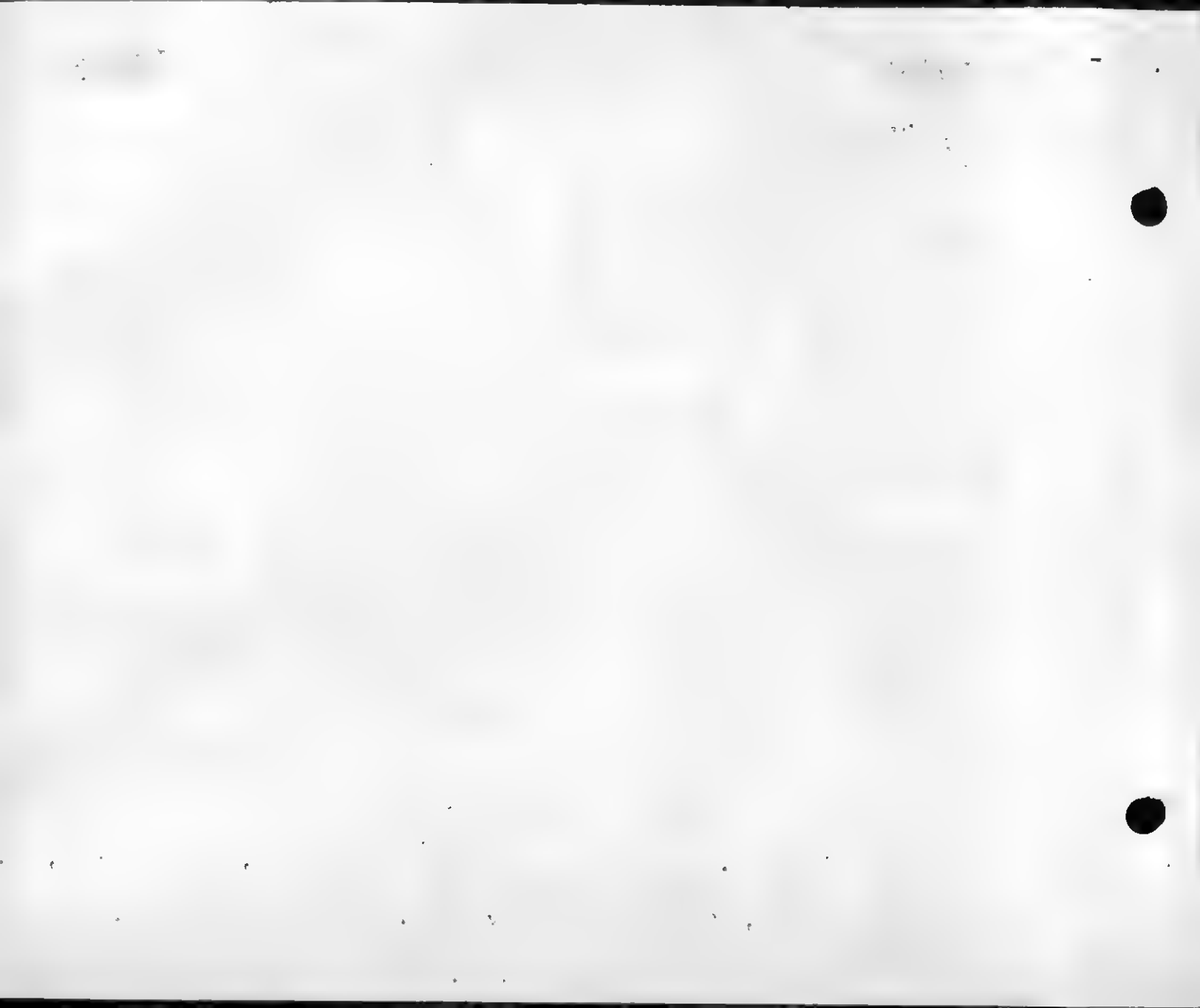
14465

## CERTIFICATE OF DEATH

14465

Item #6 infor, taken from birth cert

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>2513 Catroll Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Edward</u> Last <u>SNESKO</u>		4. DATE OF DEATH Month <u>October</u> Day <u>5</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-4-22</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>20</u> Hours <u>22</u> Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Edward Williams</u>		14. MOTHER'S MAIDEN NAME <u>Mary Rita Snisko</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>mother</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Preexisting</u> DUE TO (c) <u>Preexisting</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <u>10/5/66</u>
21. I certify that (I) (this hospital) attended the deceased from <u>10/4/66</u> , 19 <u>66</u> , to <u>10/5/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/5/66</u> , 19 <u>66</u> , and that death occurred at <u>4:00</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard J. Hollander, M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Richard J. Hollander</u>		22d. ADDRESS <u>1110 Spring Street, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct 10, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Silver Spring, Md.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Pike</u> DATE <u>OCT 11 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14466

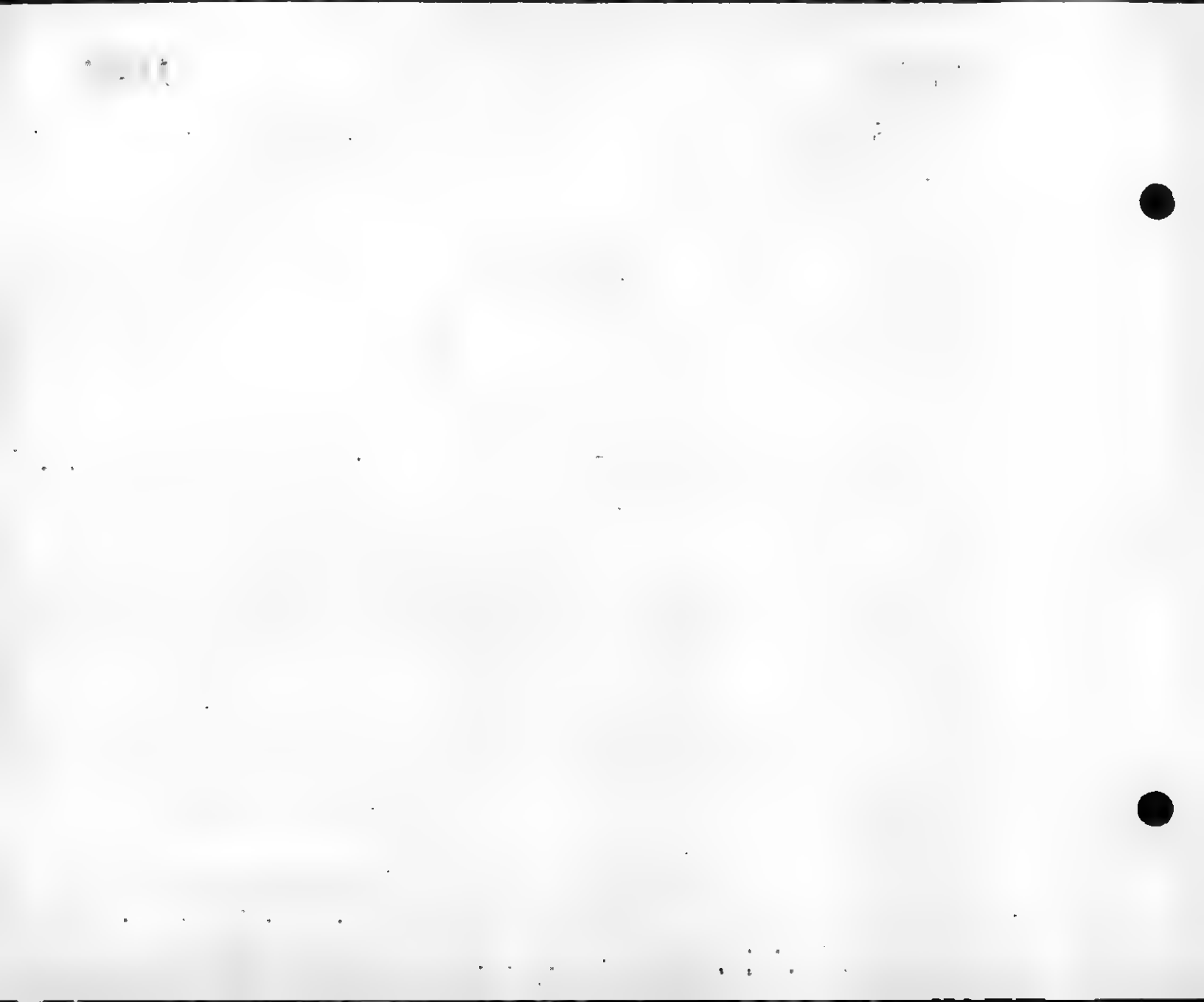
## CERTIFICATE OF DEATH

14466

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1 PLACE OF DEATH</b> a COUNTY <u>Montgomery</u> MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c LENGTH OF STAY IN lb <u>8 days</u> d NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>		<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Anne Arundel</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambrells P.O.</u> d STREET ADDRESS <u>Underwood Rd. Rt 424</u> e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3 NAME OF DECEASED</b> (Type or print) <u>Joseph S. Somers</u> First Middle Last <b>4 DATE OF DEATH</b> <u>10 - 22 - 1966</u> Month Day Year		<b>5 SEX</b> <u>M</u> <b>6 COLOR OR RACE</b> <u>Wh.</u> <b>7 MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8 DATE OF BIRTH</b> <u>11-28-98</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9 AGE</b> (In years last birthday) <u>67</u> yrs <b>10a USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Evening Star</u> <b>10b KIND OF BUSINESS OR INDUSTRY</b> <u>Retired Pressman</u> <b>11 BIRTHPL</b> E (County & State, or foreign country) <u>Tennessee</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>James Somers</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Myrtle Price</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <u>World War II</u> <b>16 SOCIAL SECURITY NO.</b> <u>579-03-2994</u> <b>17 INFORMANT</b> <u>Caroline S. Hodgkin</u> Address <u>5126 7th St. N.W. Washington, D.C.</u>	
<b>18 CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Arteriosclerosis obliterans</u>		INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>day</u> <u>years</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Pulmonary embolus</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>20b DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u> <b>20d INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>10/15</u> , 19 <u>66</u> to <u>10/22</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>10/22</u> 19 <u>66</u> , and that death occurred at <u>2:00 P.M.</u> from causes on and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Kenneth Cruze</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>Kenneth Cruze</u>		<b>22b. DATE SIGNED</b> <u>10/23/66</u> <b>22d. ADDRESS</b> <u>831 University Blvd E. S.S.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>burial</u> <b>23b. DATE THEREOF</b> <u>10/26/66</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National Cem. Ft. Myer, Va.</u> <b>23d. LOCATION (City or Town) (County) (State)</b>		<b>24. FUNERAL DIRECTOR</b> <u>The S.H. Hines Company</u> ADDRESS <u>2901 14th St. N.W. Washington, D.C.</u> <b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u> DATE <u>OCT 26 1966</u> <b>25b. REGISTRAR'S SIGNATURE</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

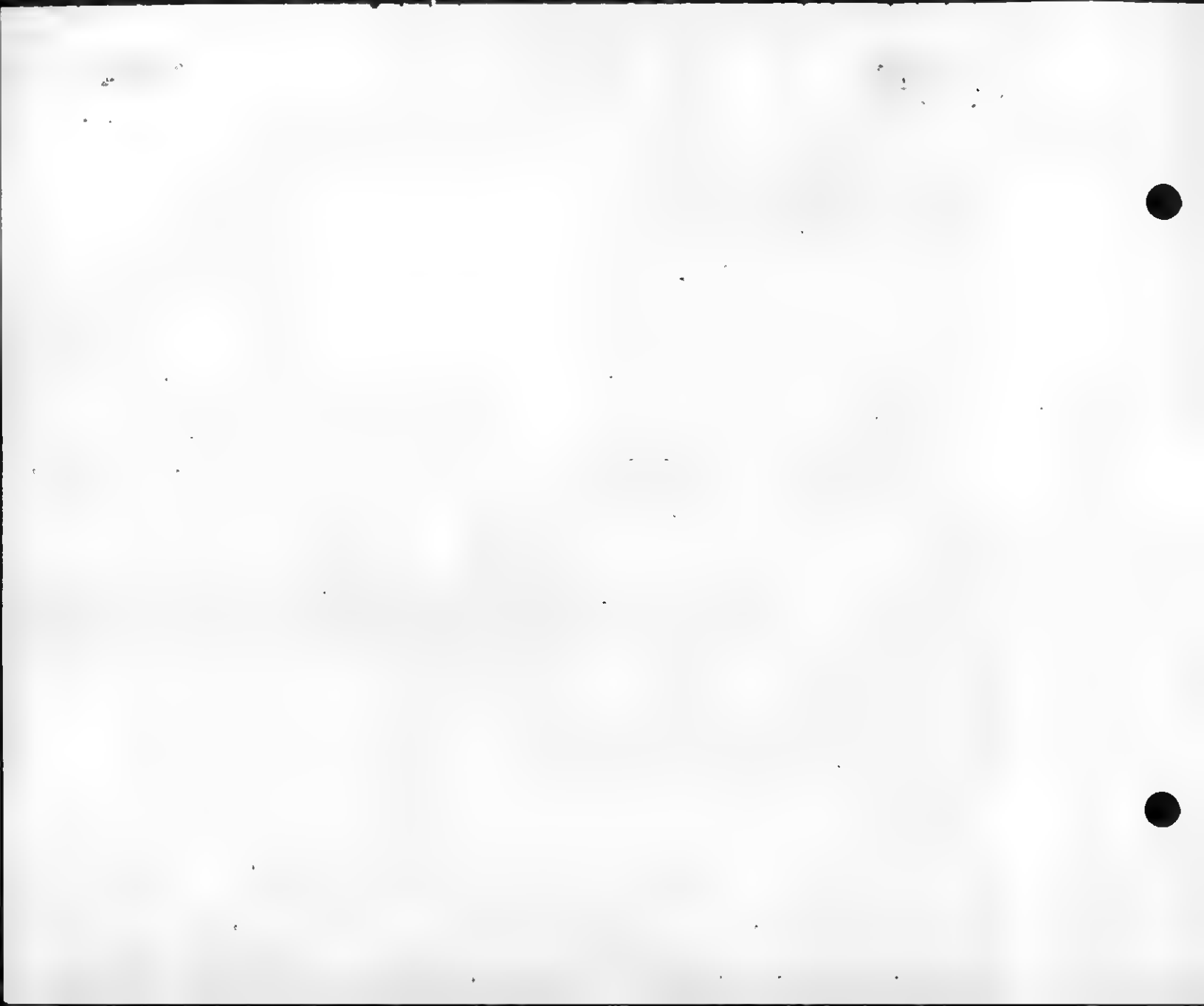
14467

## CERTIFICATE OF DEATH

14467

<b>1 PLACE OF DEATH</b> a COUNTY <u>Montgomery</u> MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c LENGTH OF STAY IN 1b <u>1 month</u> d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rosmar Sanitarium</u>				<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> d STREET ADDRESS <u>8514 Remick Road</u> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3 NAME OF DECEASED</b> (Type or print) <u>Georgia T. W. Spencer</u> First Middle Last				<b>4 DATE OF DEATH</b> <u>October 14</u> 19 <u>66</u> Month Day Year									
<b>5 SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7 MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8 DATE OF BIRTH</b> <u>Oct 11 1879</u>		<b>9 AGE</b> (In years last birthday) <u>87</u> yrs		<b>10 UNDER 1 YEAR</b> Months Days <b>10 UNDER 24 HRS</b> Hours Min			
<b>10a USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>OWN HOME</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>North Carolina</u>				<b>12 CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Alexander Wilkerson</u>						<b>14 MOTHER'S MAIDEN NAME</b> <u>Isabelle Wedding</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO</b> <u>240-22-4066</u>		<b>17. INFORMANT</b> <u>Virginia Spencer Nice</u> <u>5133 34th Street South St. Petersburg, Florida</u>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1538 Vaso-motor failure</u> DUE TO (b) <u>Cx of Colon</u> DUE TO (c) <u>Arteriosclerosis Heart dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>9/13/66</u> <b>to</b> <u>10/14/66</u> <b>that (I) (we) lost</b> <u>10/12/66</u> <b>and that death occurred at</b> <u>5:45 AM</u> <b>from causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>Stephen F. Verges</u> M.D.						<b>22b. DATE SIGNED</b> <u>10/14/66</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Stephen F. Verges - Rosmar Sanitarium</u>		<b>22d. ADDRESS</b>			
<b>23a BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Trans-burial</u>				<b>23b. DATE THEREOF</b> <u>Oct 17, 1966</u>		<b>23c NAME OF CEMETERY OR CREMATORY</b> <u>New Garden Cemetery</u>				<b>23d LOCATION</b> (City or Town) (County) (State) <u>Greensboro, North Carolina</u>			
<b>24 FUNERAL DIRECTOR</b> <u>Clark Wisor</u> <u>434 Georgia Avenue</u> <u>Warner E. Pumphrey, Inc.</u> <u>Silver Spring, Md.</u>						<b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u>		<b>25b REGISTRAR'S SIGNATURE</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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20 M 1/66



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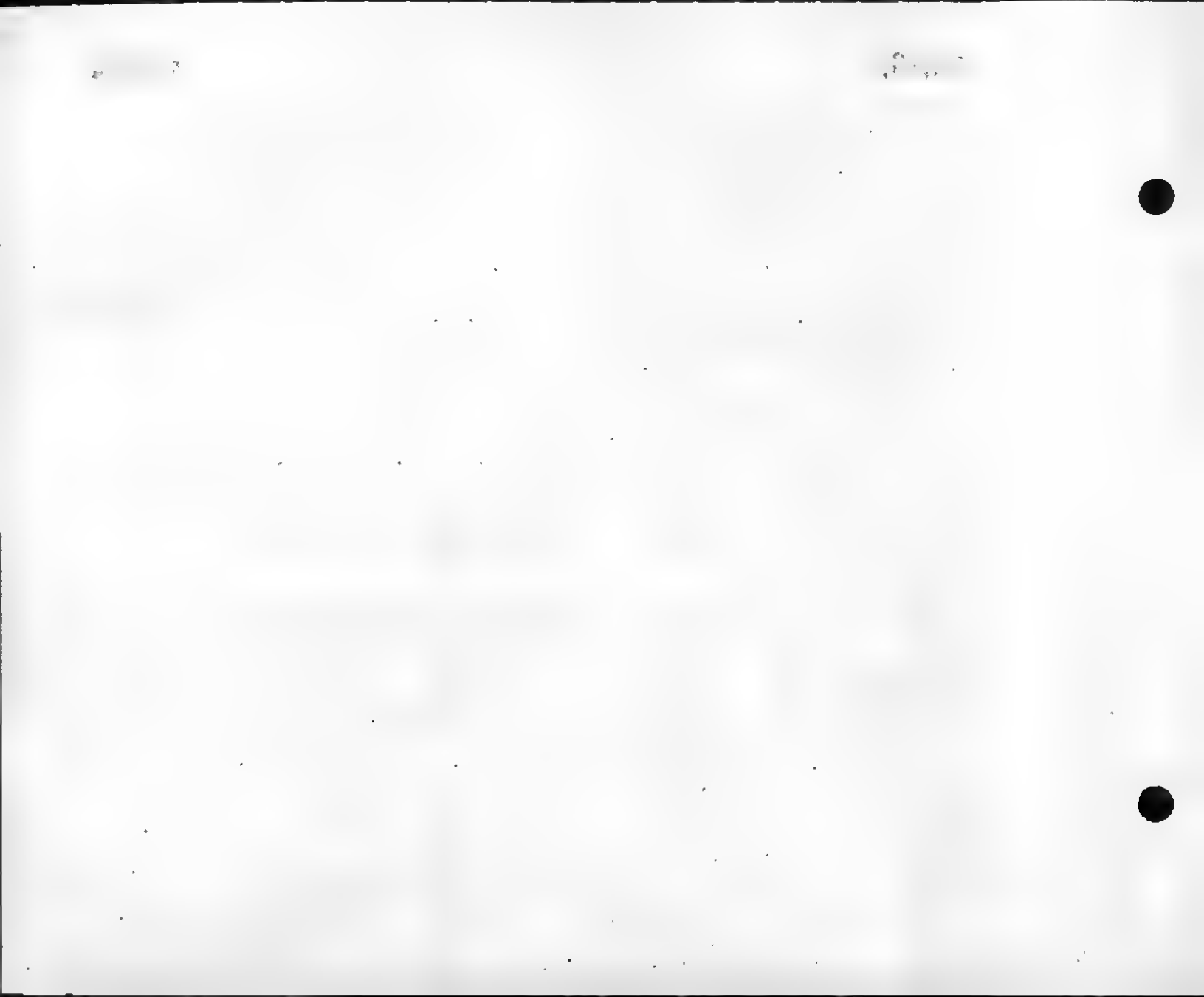
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14468

CERTIFICATE OF DEATH

14468

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Havre de Grace</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb <b>26 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. STREET ADDRESS <b>108 Vandiver Court</b>	
3. NAME OF DECEASED (Type or print) <b>Charles Joseph STALTERS</b>		4. DATE OF DEATH Month <b>October</b> Day <b>11</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 11, 1901</b>
9. AGE (In years last birthday) <b>65 yrs</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. U.S. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Joseph Stalters</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ball</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO <b>215 34 2134</b>	
17. INFORMANT <b>Mrs. May E. Stalters, 108 Vandiver Court</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopulmonary Pneumonia</b> DUE TO (b) <b>Bronchogenic Carcinoma with Metastasis</b> DUE TO (c) <b></b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>Sept. 15, 1966</b> , to <b>Oct. 11, 1966</b> that (X) (we) last saw the deceased alive on <b>Oct. 11, 1966</b> , and that death occurred at <b>850AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Elliott Perlin</i>		22b. DATE SIGNED <b>Oct. 12, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Elliott PERLIN, LCDR MC</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>OCT 14 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ANGEL HILL CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>Havre de Grace, Md.</b>	
24. FUNERAL DIRECTOR <b>Madison-Mitchell</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 17 1966</b>	
Funeral Home, Havre de Grace, Maryland		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

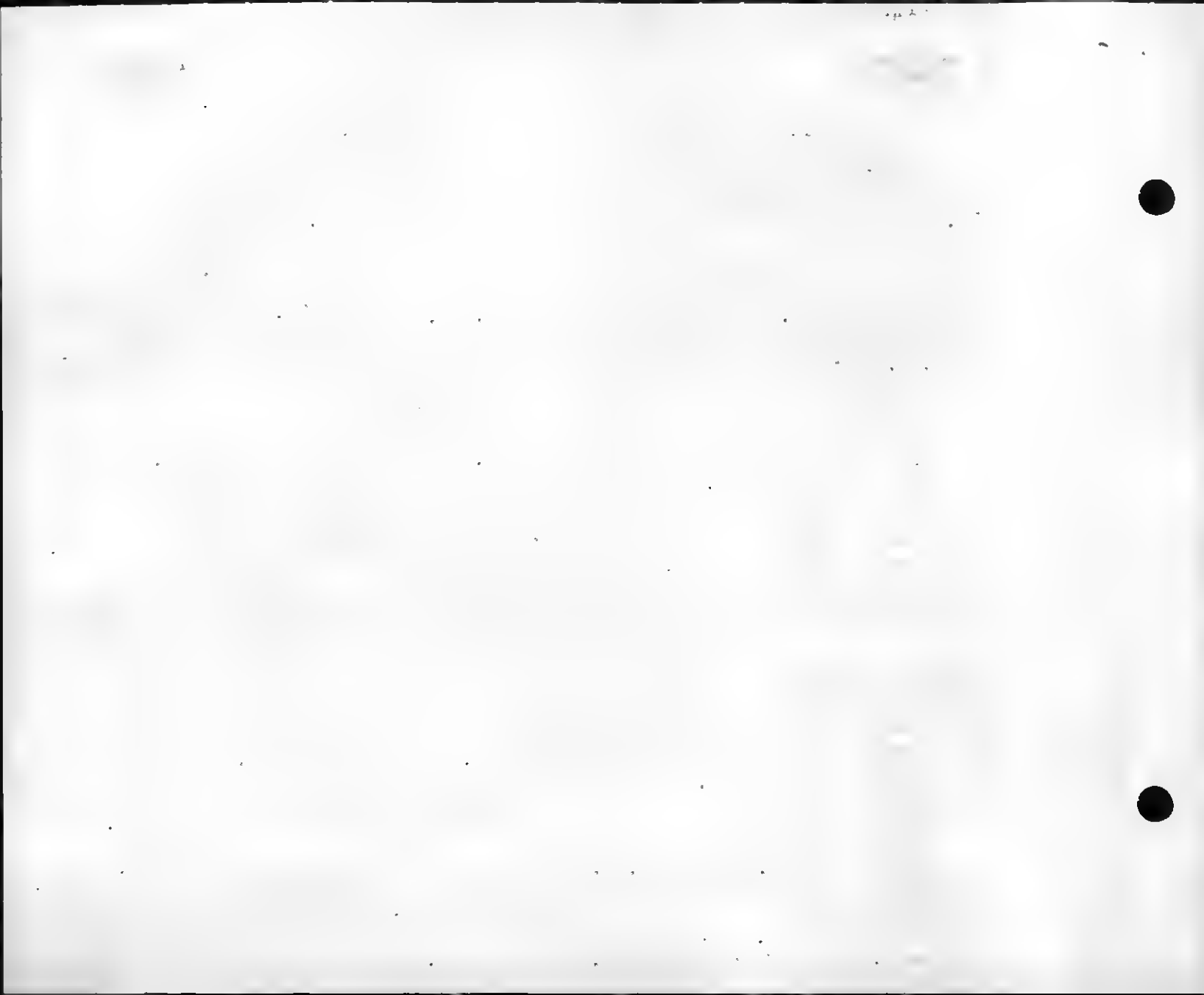
**14469**

**CERTIFICATE OF DEATH**

**14469**

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Florida</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>			c. LENGTH OF STAY IN Ib <b>43 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Miami</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				d. STREET ADDRESS <b>3170 SW 8th St., Box J905</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Charles</b> Last <b>Stask</b>				4 DATE OF DEATH Month <b>Oct.</b> Day <b>6</b> Year <b>1966</b>			
5 SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc.</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>Nov. 12, 1898</b>	
9. AGE (In years last birthday) yrs <b>67 1/2</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Philadelphia, Penn.</b>	
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes 1918-1942</b>		16. SOCIAL SECURITY NO. <b>295-24-9089</b>		17. INFORMANT <b>Miami</b> Address <b>Florida</b> <b>Mrs. Eva Stask, 3170 SW 8th St., Box J905</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS A TOLPS PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Aug. 12</b> , 19 <b>66</b> , to <b>Oct. 6</b> , 19 <b>66</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Oct. 6</b> , 19 <b>66</b> , and that death occurred at <b>202PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Robert J. Kinney</b>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>7 Oct. 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert J. Kinney, M. D.</b>				22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>10-7-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Military Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Zanesville, Ohio</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b> ADDRESS <b>Funeral Home, 7557 Wisconsin Ave. Bethesda, Md.</b>				25a. REC'D BY REGISTRAR <b>OCT 13 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

14470

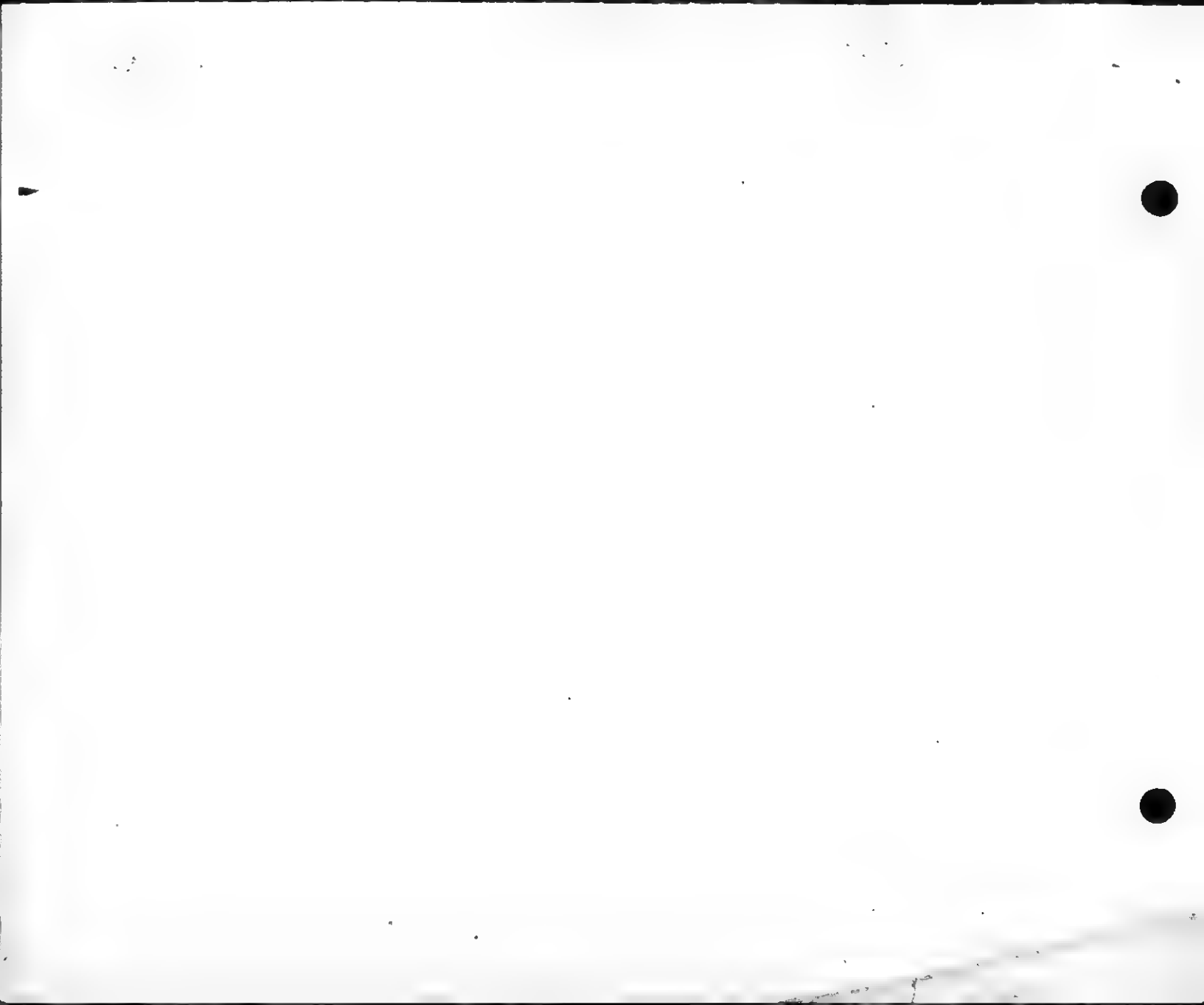
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14470

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>DOA</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Joanne J. Stewart</u>		4 DATE OF DEATH <u>Oct-31-66</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7/1/65</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY	
13 FATHER'S NAME <u>Henry J. Stewart</u>		14 MOTHER'S MAIDEN NAME <u>Josephine Schuk</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>None</u>	
17 INFORMANT <u>Father</u>		Address <u>Same as Item 2.</u>	
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Transection cervical spinal cord C-1</u> DUE TO (b) <u>Fracture dislocation, cervical vertebrae</u> DUE TO (c) <u>Automobile accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1B) <u>Passenger in car that struck a tree Thrown against windshield</u>	
20c. TIME OF INJURY Month, Day, Year <u>1:55 pm 10/31 1966</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Rockville, Montgomery Md.</u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>11/1/66</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REINTERMENT <u>Burial</u>	23b. DATE THEREOF <u>11-4-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. RECD BY REGISTRAR <u>NOV 7 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in agreement within 72 hours after death.



CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>23 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. STREET ADDRESS <b>5201 Hampden Lane</b>	
3 NAME OF DECEASED (Type or print) <b>Emma Lange</b> First Middle Last		4. DATE OF DEATH <b>October 9 1966</b> Month Day Year	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>Cauc.</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 17, 1898</b>
9 AGE (In years last birthday) <b>68</b> yrs		10 UNDER 1 YEAR Months Days Hours Min	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11b KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
12 BIRTHPLACE (County & State or foreign country) <b>Meridan, Connecticut</b>		13 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14 FATHER'S NAME <b>Ferdinand Lange</b>		15 MOTHER'S MAIDEN NAME <b>Unknown</b>	
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No N/A</b>		17 SOCIAL SECURITY NO. <b>577-01-6549</b>	
18 INFORMANT: <b>Lane, Bethesda</b> Address <b>Maryland</b> <b>M/Gen. William W. Stickney, 5201 Hampden</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration of gastric contents</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Ovarian carcinoma with widespread metastases</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>Sept. 16, 1966</b> , to <b>Oct. 9, 1966</b> , that (X) (we) last saw the deceased alive on <b>Oct. 9, 1966</b> , and that death occurred at <b>1150 M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>J. G. Roberts, M. D.</b>		22b. DATE SIGNED <b>Oct. 11, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. G. Roberts, M. D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10-13-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Funeral Home,</b> <b>7557 Wisconsin Ave., Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 13 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and notify event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14472

14472

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> <b>4 DAYS</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> <b>MONTGOMERY</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> d. STREET ADDRESS <b>16800 NORBROOK DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <b>ARTHUR EDWIN STONESTREET</b>		<b>4. DATE OF DEATH</b> Month <b>10</b> Day <b>6</b> Year <b>1966</b>		<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>8-2-92</b>		<b>9. AGE</b> (In years last birthday) <b>74</b> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>OWNER</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>MERCANTILE BUSINESS</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>CONNECTICUT</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>				<b>13. FATHER'S NAME</b> <b>ARTHUR W. STONESTREET</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>MINNIE SANDERSON</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>220-32-7426-A</b> <b>17. MEDICAL RECORDS</b>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURE LEFT VENTRICLE</b> (b) <b>ACUTE POSTERIO-LATERAL MYOCARDIAL INFARCT 4 DAYS</b> (c) <b>GENERALIZED A.S.C.V.D.</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ORGANIC BRAIN SYNDROME; PYELONEPHRITIS; PULMONARY EDEMA</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. p.m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that</b> (I) (this hospital) attended the deceased from <b>Sept 1964</b> to <b>10/6/66</b> , that (I) (we) last saw the deceased alive on <b>10/6/66</b> , and that death occurred at <b>4:40 P.M.</b> from the causes and on the date stated above.													
<b>22a. SIGNATURE</b> <b>22c. PHYSICIAN'S NAME</b> (Type) <b>D. R. LEWIS MD</b>				<b>22d. ADDRESS</b> <b>Olney, Md</b> <b>22e. DATE SIGNED</b>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>10/9/66</b>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Garrett County Memorial Gardens</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Tyson Wheeler</b>				<b>25a. REC'D BY REGISTRAR</b> <b>Charles Judge</b>				<b>25b. REGISTRAR'S SIGNATURE</b>					



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

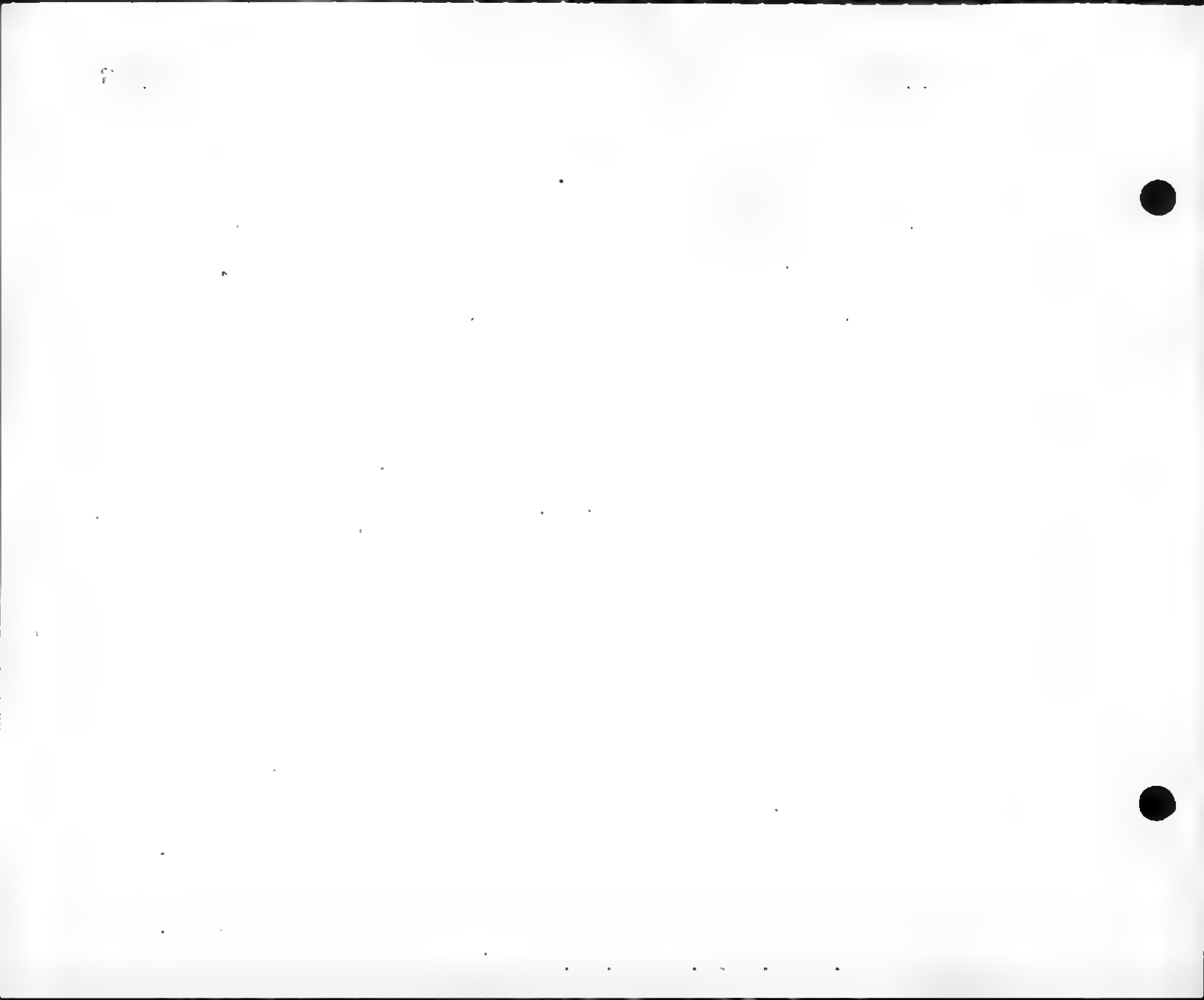
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14473

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14473

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b>			c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>				d. STREET ADDRESS <b>2106 Hil darose St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Gladys F. Story</b> First Middle Last				4. DATE OF DEATH <b>11, Oct, 66</b> Month Day Year			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10, May, 1899</b>	
9. AGE (In years last b rthday) <b>67</b> yrs		10. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Glasgow, Scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Sinnette</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>---</b>		17. INFORMANT <b>Richard R. Story - See Item #2</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> DUE TO <b>Coronary Artery Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Belden R. Reap</b> M.D.				22. DATE SIGNED <b>OCT. 11, 1966</b>			
EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-14-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland</b>	
24. FUNERAL DIRECTOR <b>Joseph Gayler's Sons, Inc.</b> ADDRESS <b>5130 Wisc. Ave. N.W. Wash. DC.</b>				25a. RECD BY REGISTRAR <b>OCT 13 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14474

CERTIFICATE OF DEATH

14474

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>14 hrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>West 3403 University Blvd</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>J</u> Last <u>Steidsberg</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>24</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/27/91</u>
9. AGE (n years last birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Mm. <u>74</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Edison Cons. (New York)</u>	11. BIRTHPLACE (County & State or foreign country) <u>New York</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Steidsberg</u>	
14. MOTHER'S MAIDEN NAME <u>Amelia Johnson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO <u>057-09-4917</u>		17. INFORMANT Address <u>Florence Sandberg-Sister - Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 20</u> , 19 <u>66</u> , to <u>Oct 24</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>Oct 23</u> 19 <u>66</u> , and that death occurred at <u>8:45</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Robert T. Thibadeau</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>10/25/66</u>
22c. PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU</u>		22d. ADDRESS <u>CITIZENS SAVINGS Bldg - KENSINGTON, MD</u>	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>10/27/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN CON.</u>	23d. LOCATION (City or Town) (County) (State) <u>BROOKLYN, N.Y.</u>
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS, INC</u>		ADDRESS <u>SILVER SPRING, MD</u>	25a. REC'D BY REGISTRAR <u>DATE OCT 28 1966</u>
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if city delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/66

FOR STATE  
HEALTH DEPT.

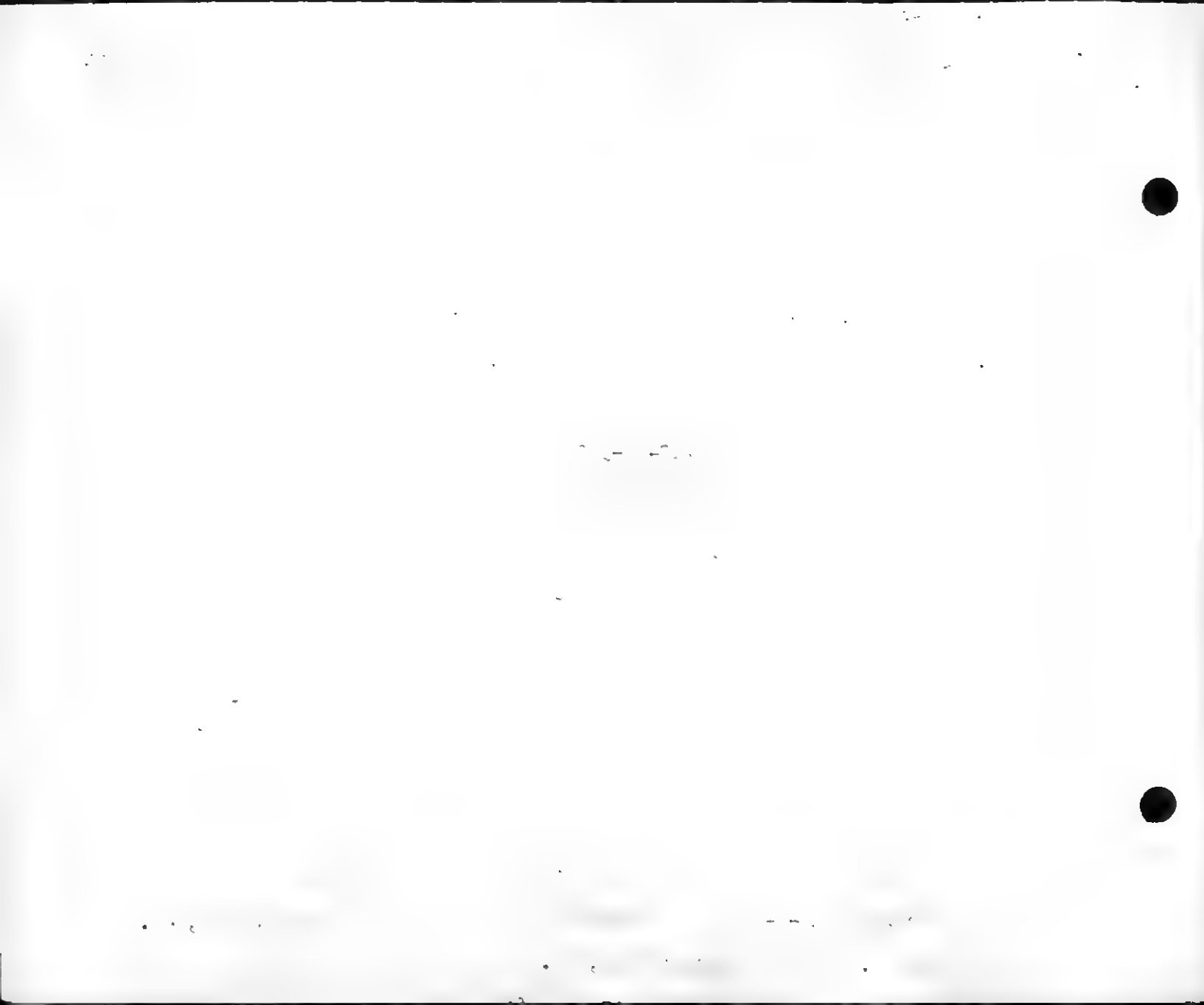
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14475

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14475

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>		d. STREET ADDRESS <i>300 N. Adams St.</i>	
3 NAME OF DECEASED (Type or print) First <i>JAMES</i> Middle <i>ALLEN</i> Last <i>SWECKER</i>		4 DATE OF DEATH Month <i>Oct</i> Day <i>1</i> Year <i>1966</i>	
5 SEX <i>male</i>	6 COLOR OR RACE <i>white</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>11-14-42</i>
9 AGE (In years last birthday) <i>23</i> yrs		10 IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	
10a. OCCUPATION (Give kind of work done during most of working life even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Clarkson, Md.</i>	
11. BIRTHPLACE (State or foreign country) <i>Gaston, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Glenn Swecker</i>		14. MOTHER'S MAIDEN NAME <i>Mag Russell</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>213-40-5438</i>	
17. INFORMANT <i>Jaqueline Swecker-wife</i>		Address <i>add. same</i>	
B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Multiple, extreme, internal</i>			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last <i>Injuries including crushed thorax.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Deceased on motorcycle, struck auto which ran thru red light</i>	
20c. TIME OF INJURY Month, Day Year <i>12:00 pm 10-1-1966</i>		20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, boat, etc.) <i>Street</i>		20f. (City or town) (County) (State) <i>Rockville Montgomery, Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Reap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>BELDEN R. REAP M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <i>Oct. 1, 1966</i>		Address (Street, city, town, or county) <i>Neelsville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>10-4-66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Neelsville</i>	23d. LOCATION (City or Town) (County) (State) <i>Neelsville, Md.</i>
24. FUNERAL DIRECTOR <i>Francis H. Barber</i>		ADDRESS <i>Laytonsville, Md.</i>	
25a. RECD BY REGISTRAR <i>OCT 5 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



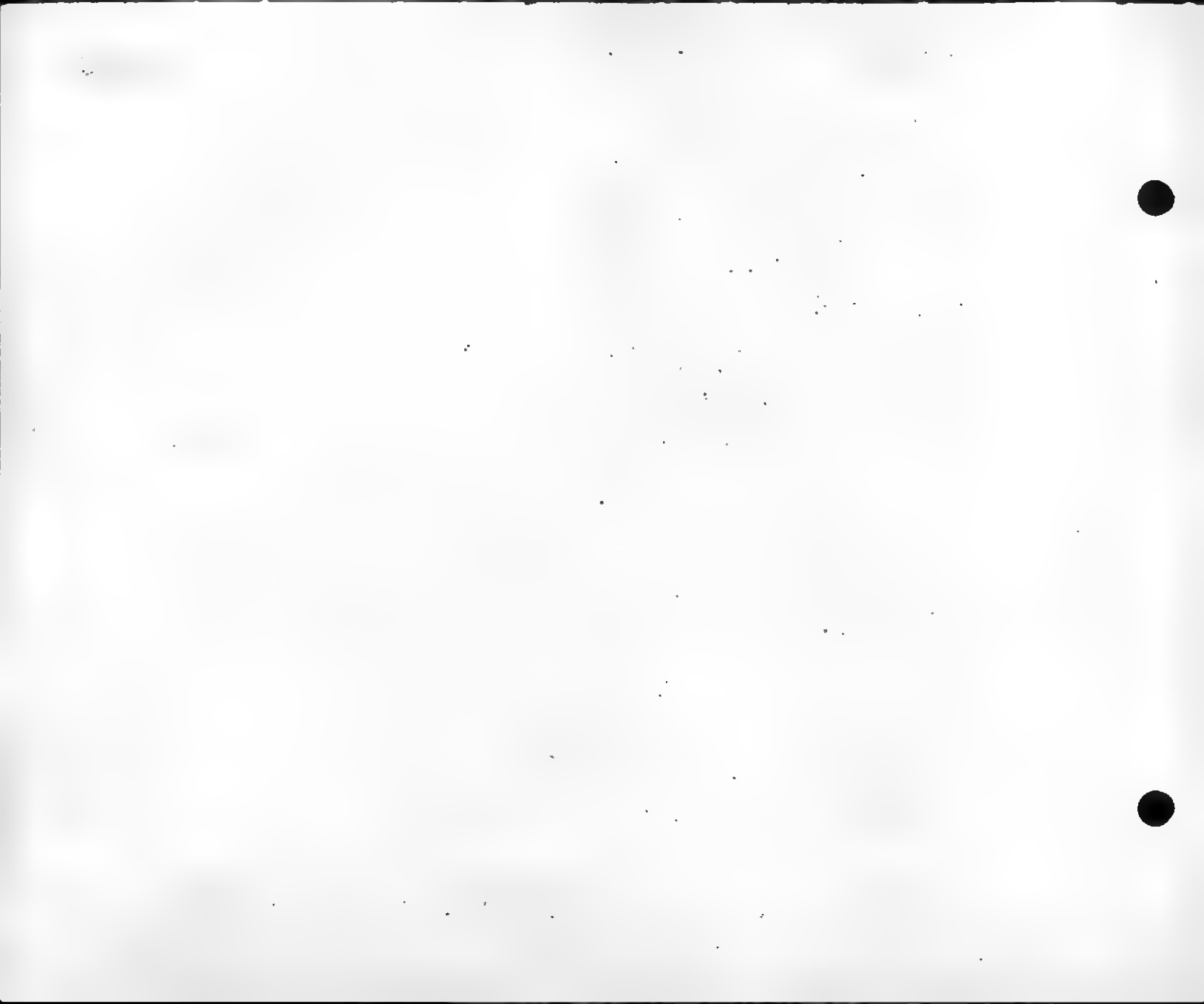
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14476 CERTIFICATE OF DEATH 14476

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u> c. LENGTH OF STAY IN 1b <u>11 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery Convalescent Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>2006 37<sup>th</sup> St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frances Rodda Sweeney</u> First Middle Last		4. DATE OF DEATH <u>10 13 1966</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 2, 1907</u>
9. AGE (In years last birthday) <u>59 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Personnel Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William George Wirth</u>		14. MOTHER'S MAIDEN NAME <u>Neuhauser</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-10-3668</u>	
17. INFORMANT <u>Ann Wirth</u>		Address <u>3900 Hamilton St. Hyattsville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apoplexy, thrombotic</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>5 yrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/11</u> , 19 <u>66</u> , to <u>10/13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/13</u> , 19 <u>66</u> , and that death occurred at <u>5:52 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>A.D. Bonifant</u>		22b. DATE SIGNED <u>10/13/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.D. Bonifant</u>		22d. ADDRESS <u>Sandy Spring Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-17-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington National Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Suitland Maryland</u>
24. FUNERAL DIRECTOR <u>J. Wm Lee &amp; Sons, 300 4th St. NE, Wash, DC</u>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>OCT 18 1966</u>			

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14477

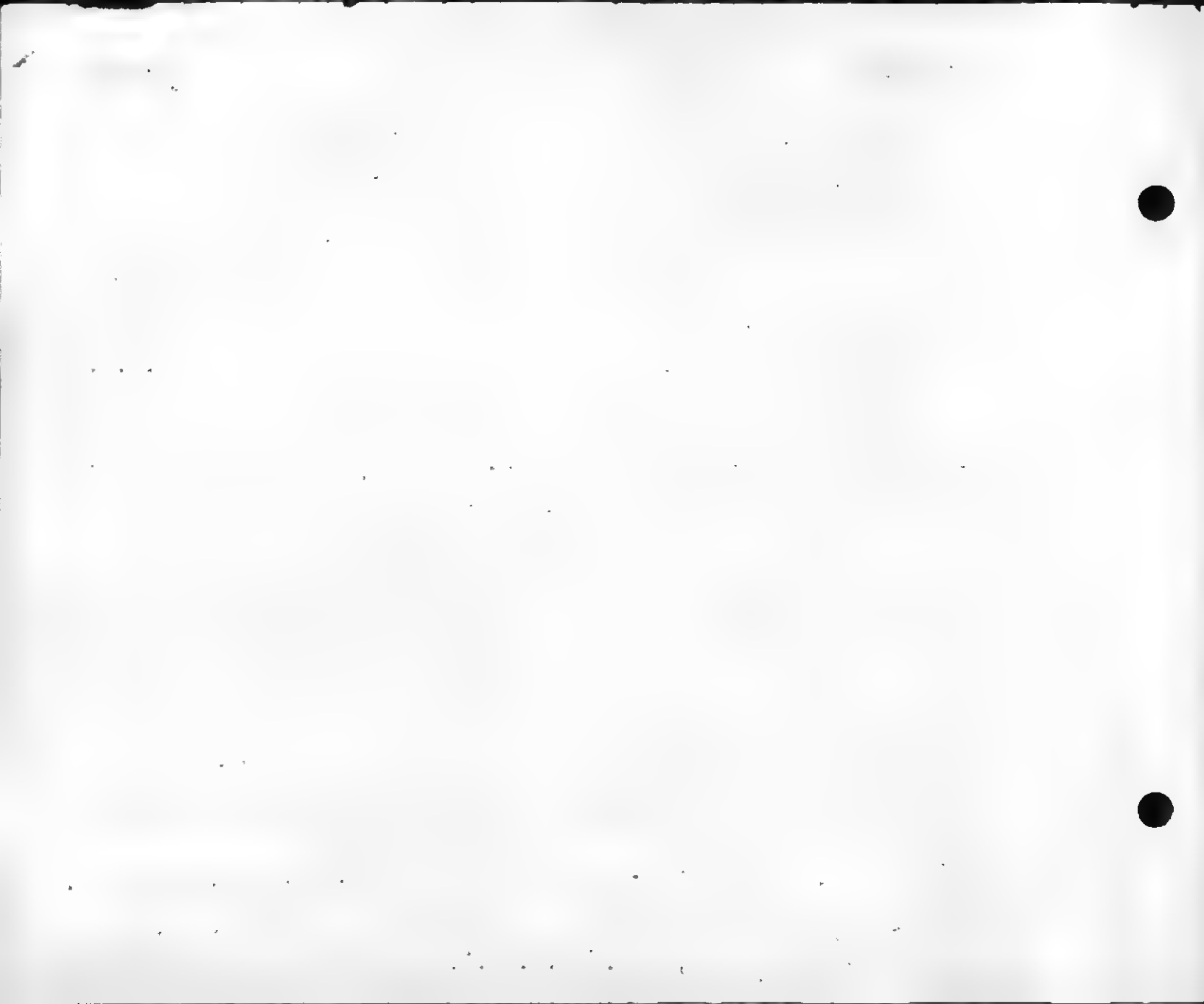
## CERTIFICATE OF DEATH

14477

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. LENGTH OF STAY IN 1b <b>Chevy Chase</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6409 Kennedy Drive</b>		d. STREET ADDRESS <b>6409 Kennedy Drive</b>	
3 NAME OF DECEASED (Type or print) <b>HAROLD MORTON TALBURT</b>		4. DATE OF DEATH Month <b>October</b> Day <b>22</b> Year <b>19 66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Caucasian</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>2-19-1895</b>
9 AGE (In years last birthday) <b>71</b> yrs		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cartoonist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>- - -</b>		16. SOCIAL SECURITY NO <b>- - -</b>	
17 INFORMANT <b>Mrs. Frances Karn Talburt</b>		Address <b>See Item No. 2</b>	
18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adeno carcinoma Pancreas</b> DUE TO <b>with metastases to liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO DUE TO DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>8 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1963</b> to <b>10-22, 1966</b> , that (I) (we) last saw the deceased alive on <b>10-21, 1966</b> , and that death occurred at <b>2:15 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>J. Blaine Fitzgerald</b>		22b. DATE SIGNED <b>10/22/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. Blaine Fitzgerald</b>		22d. ADDRESS <b>8218 Wis. Ave. Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>10-24-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland, Md.</b>
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 27 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



14478

## CERTIFICATE OF DEATH

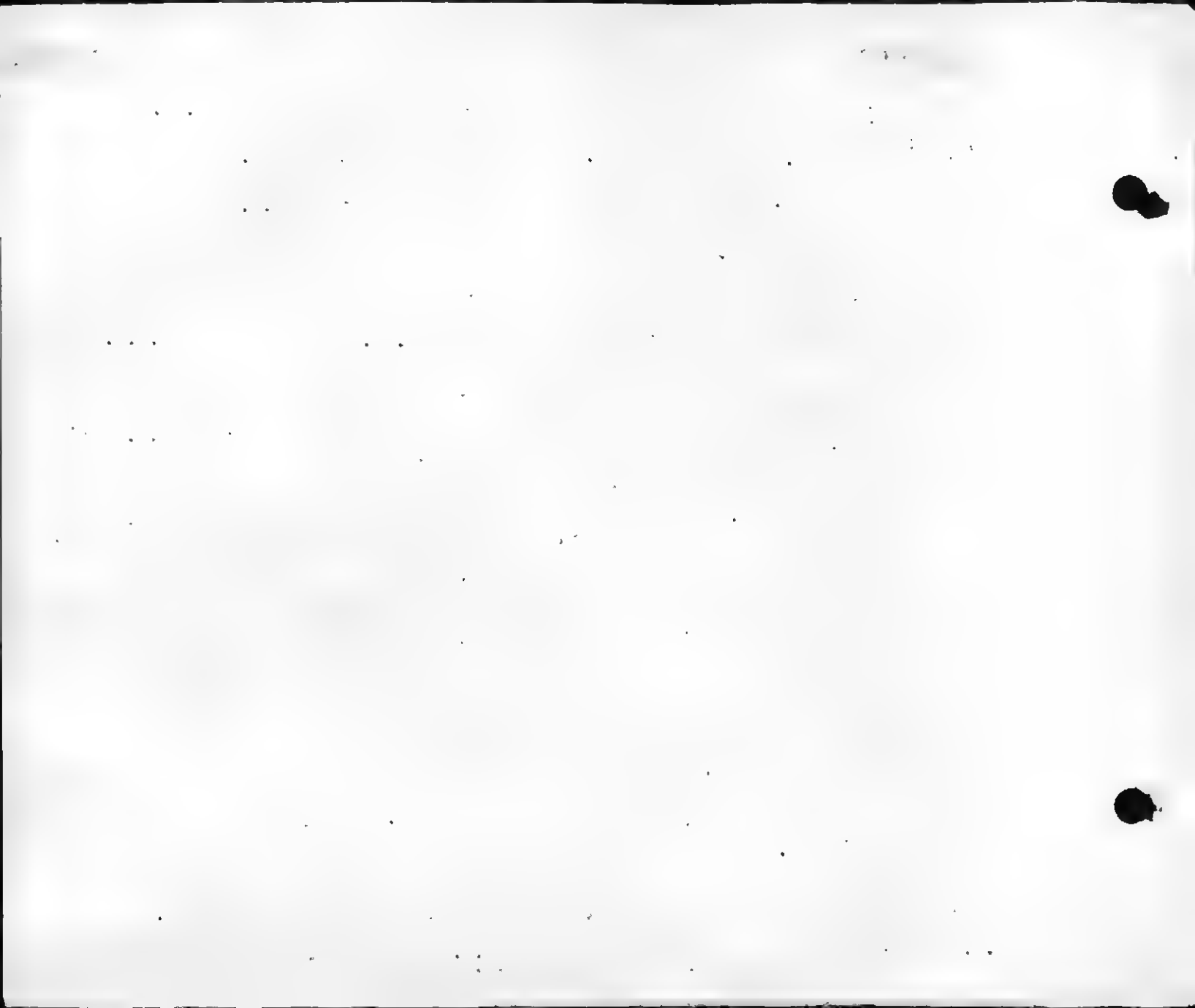
Reg. Dist. No.

14478

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) b. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u>		c. LENGTH OF STAY IN 1b <u>2 Weeks.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Holy Cross Hospital.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph L Talley</u> First Middle Last		4. DATE OF DEATH <u>Oct 24 1966</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/1/97</u>
9. AGE (In years (b) birthday) yrs. <u>69</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u>	
11. BIRTHPLACE (State or foreign country) <u>Kinston N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William P Talley</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Hartfield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Mrs Martha L Talley 5922 13th St N.W. Wife</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO <u>Post-operative carotid endarterectomy and 2 lobectomy in Ca of lung</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>I</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis; portal cirrhosis; gastritis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>22 weeks</u> <u>I</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-9</u> 19 <u>66</u> , to <u>10-24</u> 19 <u>66</u> , that I last saw the deceased alive on <u>10-24</u> 19 <u>66</u> , and that death occurred at <u>9:20 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jason Geiger</u> M.D.		ADDRESS (Street, city or town, state) <u>800 PERSHING DRIVE</u> DATE SIGNED <u>10-25</u>	
PHYSICIAN'S NAME (Type) <u>JASON GEIGER, M.D.</u>		<u>SILVER SPRING, MD.</u> <u>66</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/28/66</u>	22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Huntman &amp; Son</u>		ADDRESS <u>5732 Georgia Ave N.W.</u>	24a. REC'D BY REGISTRAR <u>Charles Judge</u>
		DATE <u>OCT 27 1966</u>	24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14479						14479					
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b> c. LENGTH OF STAY IN MD <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>University Nursing Home</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>New York City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New York City</b> d. STREET ADDRESS <b>60 East 94th St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF (Type or print) <b>MAX</b>						4. DATE OF DEATH Month <b>10</b> Day <b>3</b> Year <b>1966</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>Cauc.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/24/80</b>		9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>3</b> Hours <b>1966</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Taschman</b>						14. MOTHER'S MAIDEN NAME <b>Fannie</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT <b>Harvey Taschman</b> Address <b>168 Fleetwood Ter., Sil. Sp. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio -</b> Conditions, if any, which gave rise to immediate cause } DUE TO (b) <b>Vascular Brain Disease</b> (c), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>10/8</b> p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <b>10/8</b> <b>1966</b> to <b>10/3</b> <b>1966</b> , that (I) (we) last saw the deceased alive on <b>10/2</b> <b>1966</b> , and that death occurred at <b>11:30</b> M. from the causes and on the date stated above.											
21. I certify that (I) (this hospital) attended the deceased from <b>10/8</b> <b>1966</b> to <b>10/3</b> <b>1966</b> , that (I) (we) last saw the deceased alive on <b>10/2</b> <b>1966</b> , and that death occurred at <b>11:30</b> M. from the causes and on the date stated above.						22a. SIGNATURE <b>William Brannan</b> M.D. 22b. DATE SIGNED <b>10/26/66</b>					
22c. PHYSICIAN'S NAME (Type) <b>W M BRAININ</b>						22d. ADDRESS <b>6124 Central Ave, Capitol Hgts Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Hastings, New York</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>B. Danzansky &amp; Sons</b>						25a. REC'D BY REGISTRAR <b>St., N.W., Wash., D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

100



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14480

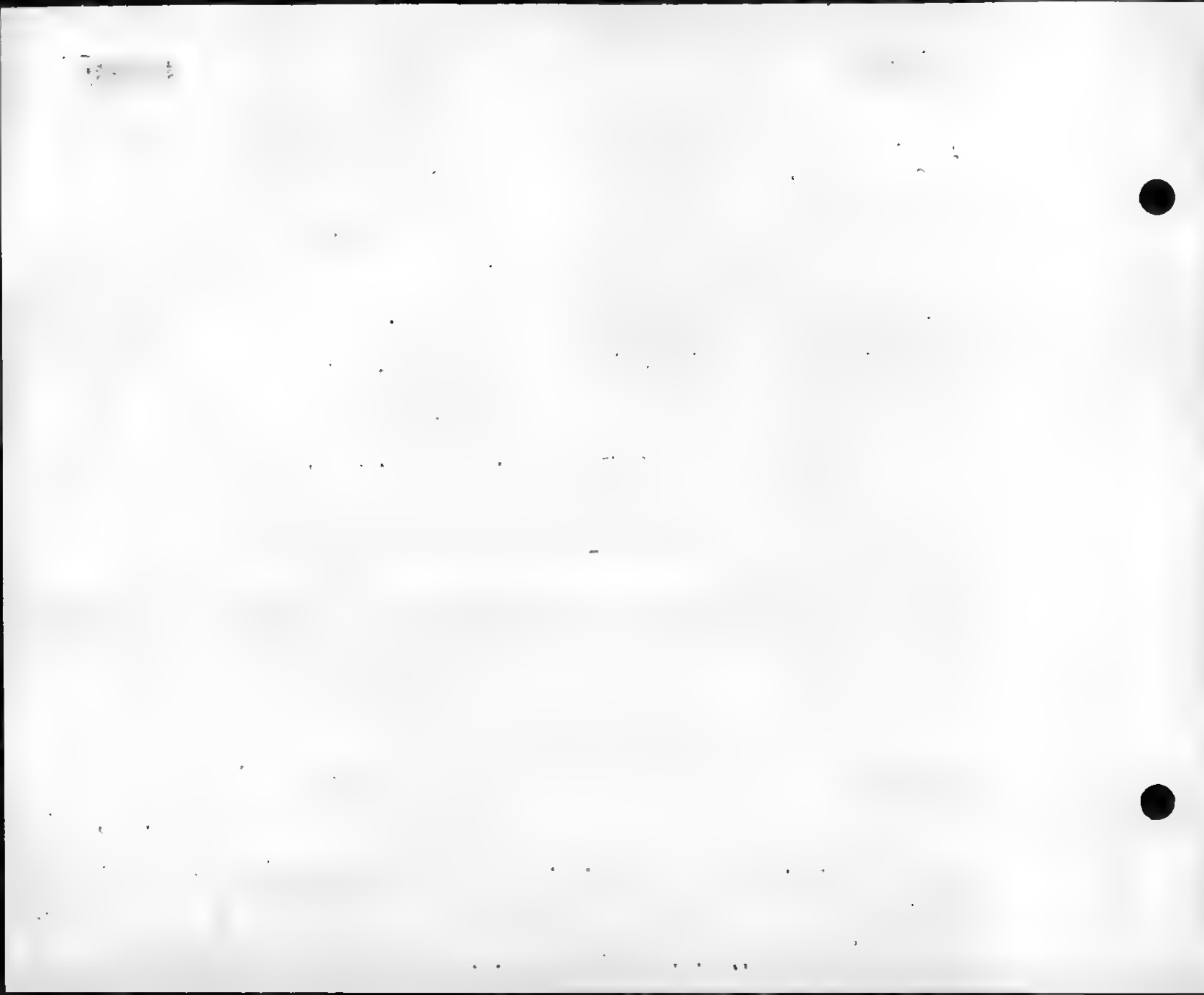
## CERTIFICATE OF DEATH

14480

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>			c. LENGTH OF STAY IN 1b <b>37 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda,</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				d. STREET ADDRESS <b>4977 Battery Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Phillip</b> Last <b>THEW</b>				4. DATE OF DEATH Month <b>October</b> Day <b>19</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 10. 1903</b>		9. AGE (In years last birthday) <b>63 yrs</b>	IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Captain USN</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>ARMED FORCES</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Allegan, Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Charles Thew</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>yes 1924-1953</b>		16. SOCIAL SECURITY NO. <b>083-36-5646</b>		17. INFORMANT <b>Bethesda,</b> Address <b>Maryland</b> <b>Mr. Robert W. Thew, 4977 Battery Lane</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial pneumonia</b> <b>171X</b> DUE TO (b) <b>Carcinoma prostate with extensive metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b></b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b></b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b></b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>	
21. I certify that (If this hospital) attended the deceased from <b>September 19 66</b> , to <b>Oct. 19, 19 66</b> that (If we) last saw the deceased alive on <b>October 19 19 66</b> , and that death occurred at <b>955 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>F. J. Frensilli</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Oct. 21, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. J. Frensilli M. D.</b>				22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/24/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler &amp; Sons</b> ADDRESS <b>5130 Wisconsin Ave., N.W. Washington, D.C.</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 27 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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Item 21 Film 381 10-21 MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
14481 CERTIFICATE OF DEATH 14481															
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>35 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>McLean</b> d. STREET ADDRESS <b>1825 Dalmation Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Mariann</b>			First <b>(None)</b>			Middle <b>Thompson</b>			Last <b>October</b>			4. DATE OF DEATH Month <b>12</b> Day <b>19</b> Year <b>66</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>16 February 1920</b>		9. AGE (In years last birthday) <b>46 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Missouri</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Charles Leach</b>						14. MOTHER'S MAIDEN NAME <b>Elizabeth Grieve</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>515-03-3040</b>				17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda, Md. 20014</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>2043</b> DUE TO <b>Serratia Septicemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Serratia Septicemia</b> DUE TO <b>Acute Lymphocytic Leukemia</b> (c) <b>Acute Lymphocytic Leukemia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>35 days</b> <b>22 months</b>															
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)															
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Sept. 7, 1966</b> to <b>Oct. 12, 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>October 12, 1966</b> and that death occurred at <b>4:50 PM</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>Jerry L. Spivak</b>						22b. DATE SIGNED <b>10/12/66</b>									
22c. PHYSICIAN'S NAME (Type) <b>Jerry L. Spivak, MD.</b>						22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>10/14/66</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b>				23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>			
24. FUNERAL DIRECTOR <b>Charles Judge</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				DATE <b>OCT 17 1966</b>			



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14482

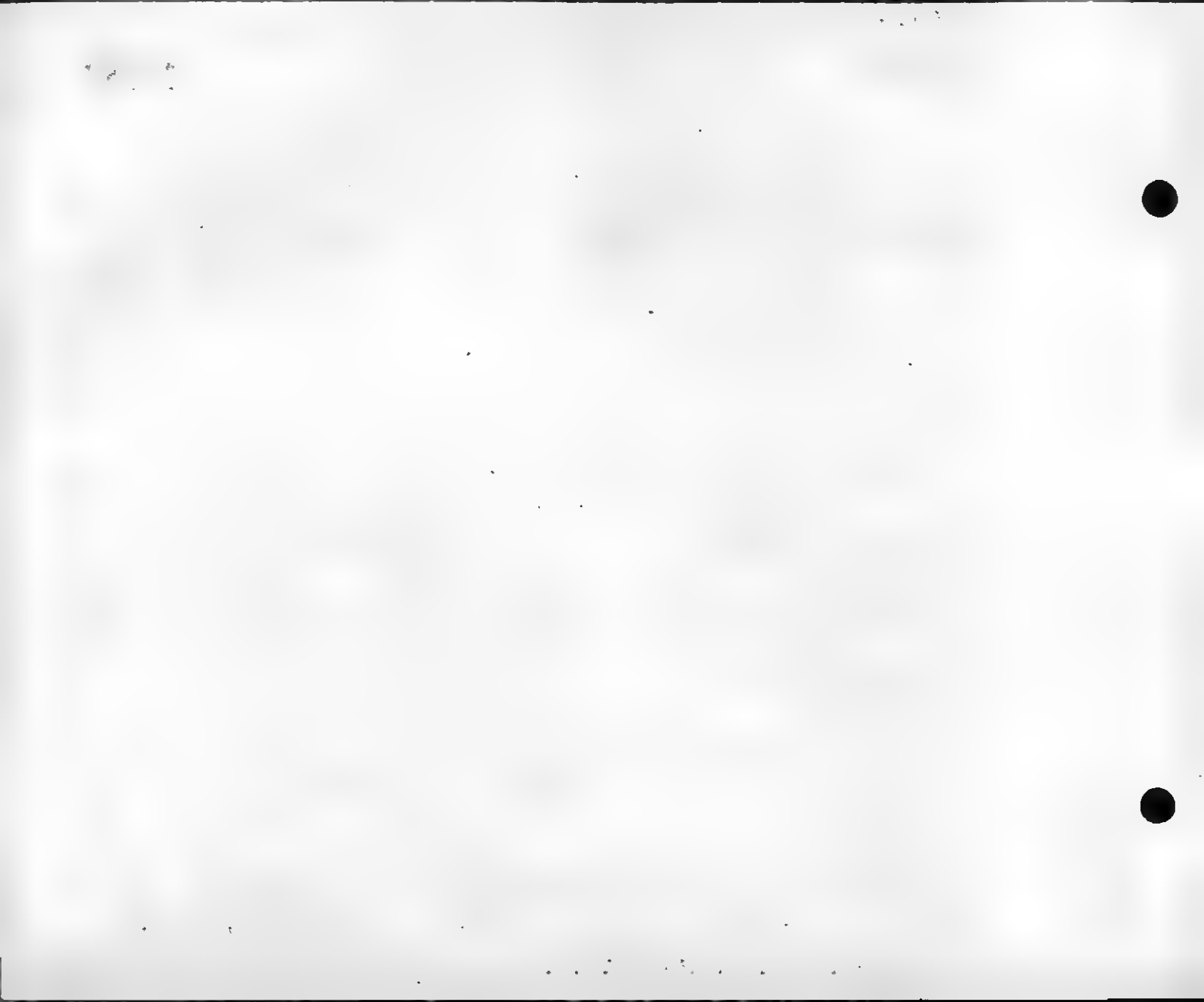
14482

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 9 Film 352 11/7/66 mh

CERTIFICATE OF DEATH

14482

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>17 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>		d. STREET ADDRESS <u>49 OBSERVATION Circle</u>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>B.</u> Last <u>Tweedy</u>		4. DATE OF DEATH Month <u>October</u> Day <u>28</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 25, 1877</u>
9. AGE (In years last birthday) <u>89</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James B BURBANK</u>		14. MOTHER'S MAIDEN NAME <u>Alice White</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Hospital Records-</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>arteriosclerotic C-V disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs</u> <u>5 yrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/14, 1966</u> , to <u>10/28, 1966</u> that (I) (we) last saw the deceased alive on <u>10/28, 1966</u> , and that death occurred at <u>11:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>H. F. Kreuzburg</u>		22b. DATE SIGNED <u>10/29/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. F. Kreuzburg</u>		22d. ADDRESS <u>7852 16th Ave West 12</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>11-2-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wooster Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Danbury, Conn.</u>	
24. FUNERAL DIRECTOR <u>Joseph Jewler's Sons, Inc.</u> <u>5130 Wise Ave. N.W., Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 3 1966</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

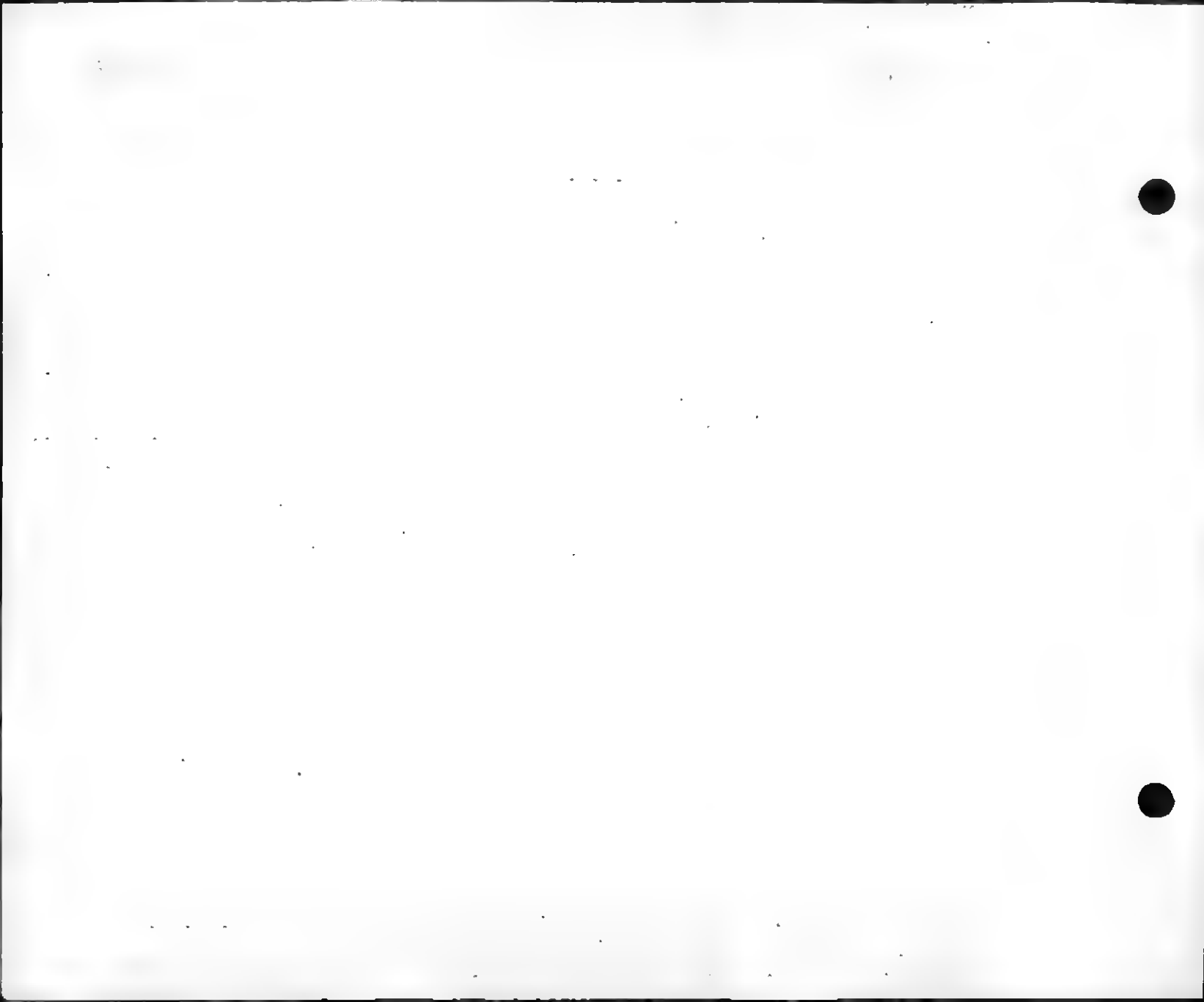
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14483

14483

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY in 1b <u>D.O.A.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. &amp; Hospital</u>		d STREET ADDRESS <u>8511 Flower Ave</u>	
3 NAME OF DECEASED (Type or print) <u>Mrs. Zillah Winn Upton</u>		4 DATE OF DEATH Month <u>10</u> Day <u>19</u> Year <u>1966</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-3-05</u>
9 AGE (in years last birthday) <u>60</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11 BIRTHPLACE (State or foreign country) <u>Temperanceville Va</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Rev. J. Arthur Winn</u>		14 MOTHER'S MAIDEN NAME <u>Zillah Mapp</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>Yes</u>	
17 INFORMANT <u>Son - John A. Upton</u>		18 ADDRESS <u>8511 Flower Ave., Jk. Pl., Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Essential Hypertension</u> (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Read</u> M.D.		22. DATE SIGNED <u>OCT. 20, 1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. READ M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) <u>Charles Judge</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Oct. 22, 1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>
24 FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u> 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

Items 18&21 Film 382 11-14 MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14484		MEDICAL EXAMINER'S CERTIFICATE OF DEATH						14484			
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>					
b. CITY OR TOWN (If outside corporate limits, write R.R., Rd. and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>3 1/2 d.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huattsville</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>						a. STREET ADDRESS <u>2007 Chapman Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Josephine none Vernon</u>						4 DATE OF DEATH Month <u>10</u> Day <u>7</u> Year <u>1966</u>					
5 SEX <u>Female</u>		6 COLOR OR RACE <u>white</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>11-5-1899</u>		9 AGE (In years last birthday) <u>66</u> yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR IND. STRY <u>Fed. Gov.</u>		11 BIRTHPLACE (State or foreign country) <u>Pa.</u>				12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Gleason</u>						14. MOTHER'S MAIDEN NAME <u>Nora Coleman</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO		17. INFORMANT <u>Edward P. Kelly</u> Address <u>7303 16th Ave</u>					
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary artery heart disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVA. BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <u>Oct. 7, 1966</u>			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Oct 10, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring Mont Co Md</u>			
24. FUNERAL DIRECTOR <u>Arthur Walters</u> ADDRESS <u>257 Carroll St NW Wash DC</u>						25a. REC'D BY REG. STRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE		DATE <u>OCT 11 1966</u>	



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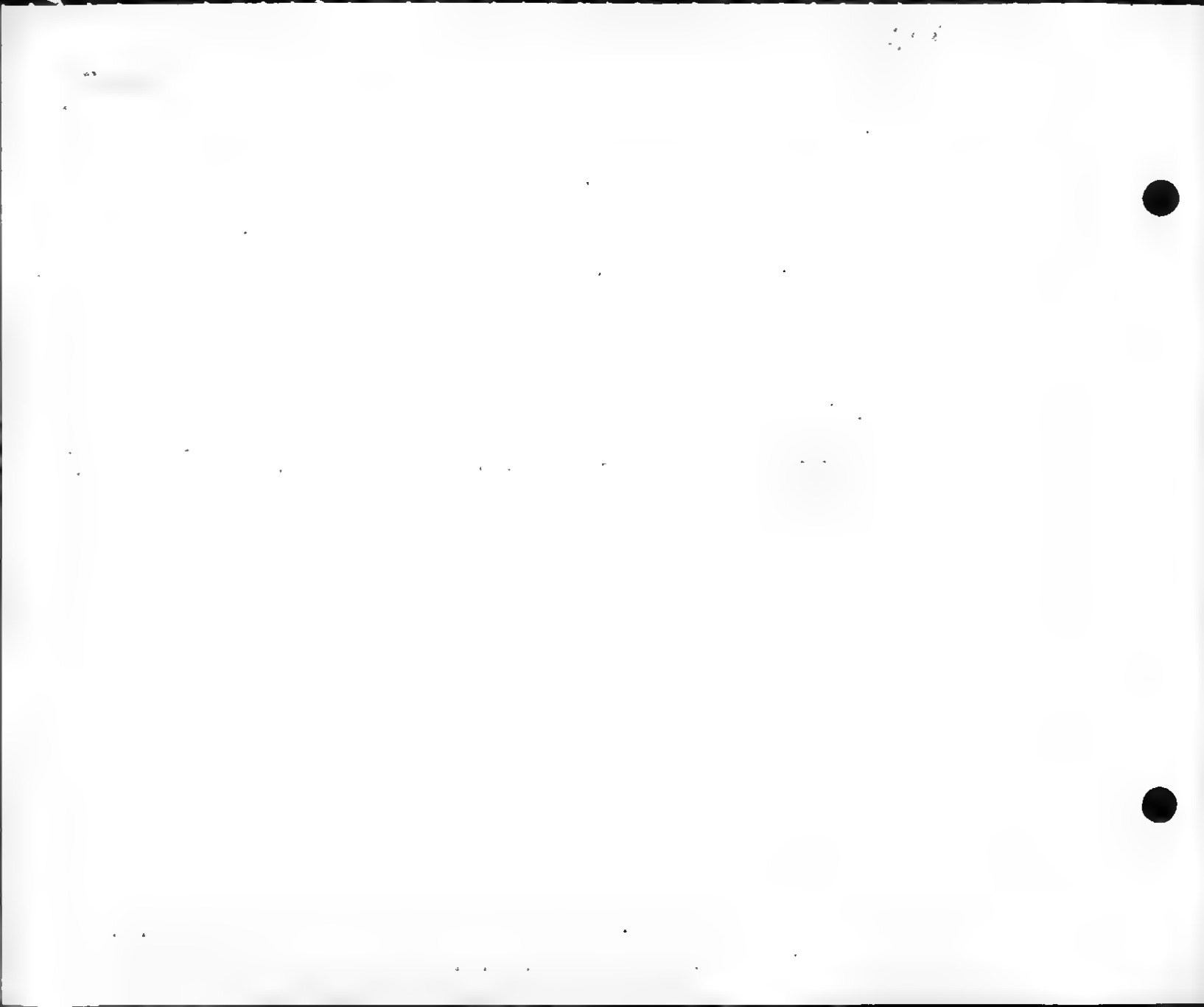
FOR STATE  
HEALTH DEPT

14485

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14485

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN Id <b>25 hrs., 34 min.</b>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to, give street address) <b>Holy Cross Hospital</b>				d. STREET ADDRESS <b>3620 Gleneagle Drive</b>			
3. NAME OF DECEASED (Type or print) First <b>Louise</b> Middle <b>Cannon</b> Last <b>Wahl</b>				4. DATE OF DEATH Month <b>October</b> Day <b>10</b> , Year <b>19 66</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/2/94</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward J. Cannon</b>				14. MOTHER'S MAIDEN NAME <b>Helen Appleton</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>578-30-9224</b>		17. INFORMANT Address <b>Rockville, Mo.</b> <b>Mrs. Alvin Dunham, 10120 Glen Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive subdural hematoma associated</b> DUE TO <b>904.0</b> (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.) (b) <b>with Rheumatic heart disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <b>Deceased fell at home apparently following a syncopal attack</b>					
20c. TIME OF INJURY Month Day Year <b>5:00<sup>hour</sup> 10-9 19 66</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) <b>Home</b>		20f. (City or town) (County) (State) <b>Silver Spring Montg Md</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>BELOEN R. REAP M.D.</b>				22. DATE SIGNED <b>Oct. 10, 1966</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/13/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington D.C.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Washington, D.C.</b>				25a. REC'D BY REGISTRAR <b>OCT 13 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Jones</b>	



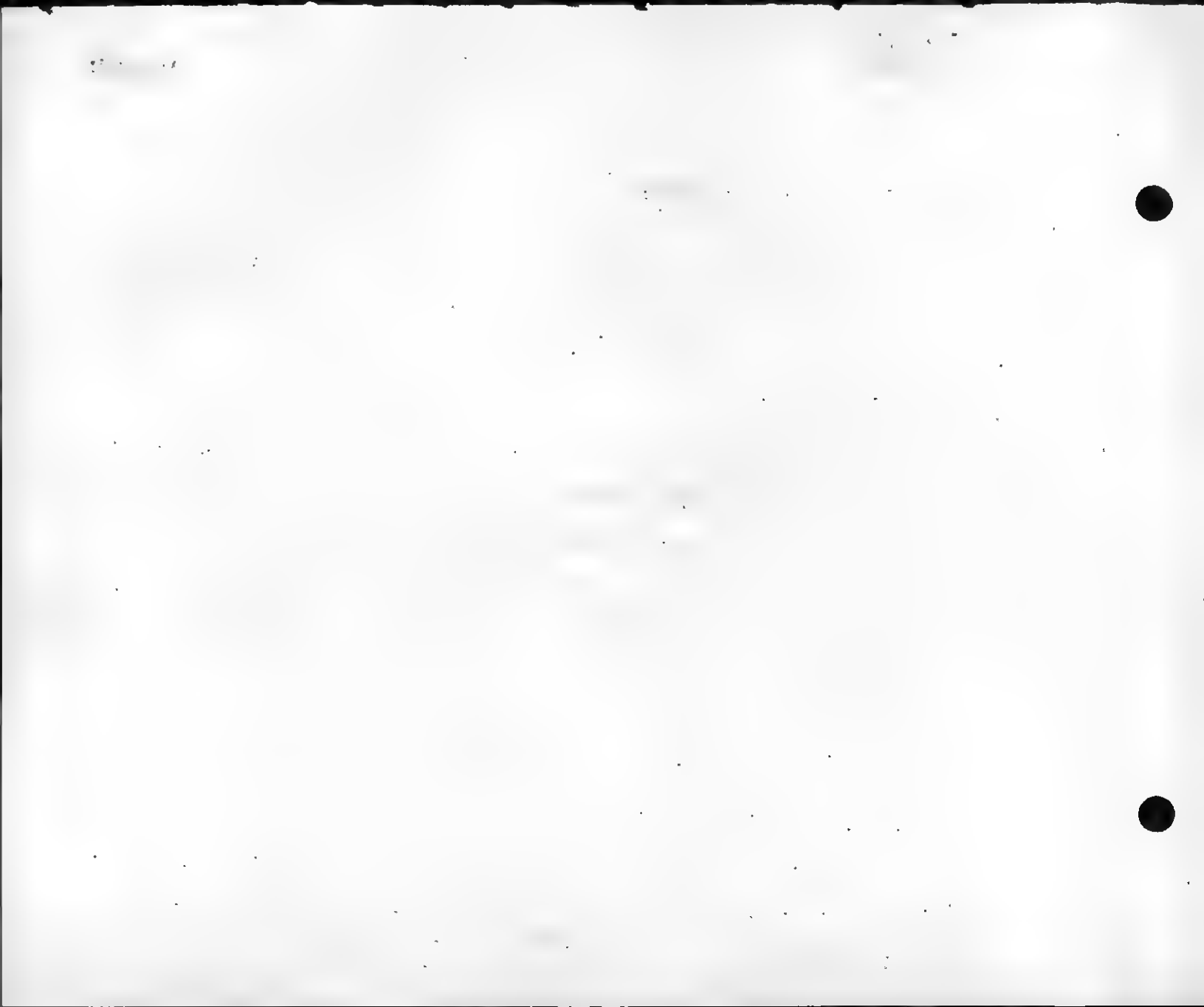
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14486					14486						
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda					b. COUNTY Montgomery						
c. LENGTH OF STAY IN ID 54 Days					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) National Institutes of Health The Clinical Center, Bethesda 14, Maryland					d. STREET ADDRESS 8412 Donnybrook Drive						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Frederick			First Harvey			Last Walck, II			4. DATE OF DEATH Month October Day 1 Year 19 66		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 20 November 1958		9. AGE (In years last birthday) 7 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY Elementary School				11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Hurley Walck						14. MOTHER'S MAIDEN NAME Elsie Tomson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) (If yes give war or dates of service) No None				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Records, The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Staphylococcal Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Bronchopneumonia DUE TO (c) Acute Lymphatic Leukemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH Days Days 3 Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from 8 August, 1966, to 1 October, 1966, that (we) last saw the deceased alive on 1 October, 1966, and that death occurred at 11:45 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Joel J. Rubenstein						22b. DATE SIGNED 2 October 1966					
22c. PHYSICIAN'S NAME (Type) Joel J. Rubenstein, MD.						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Oct. 5, 1966		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION (City, town or county) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR Clark E. Wisor Warner E. Humphrey, Inc.						25a. REC'D BY REGISTRAR 8434 Georgia Ave. Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14487

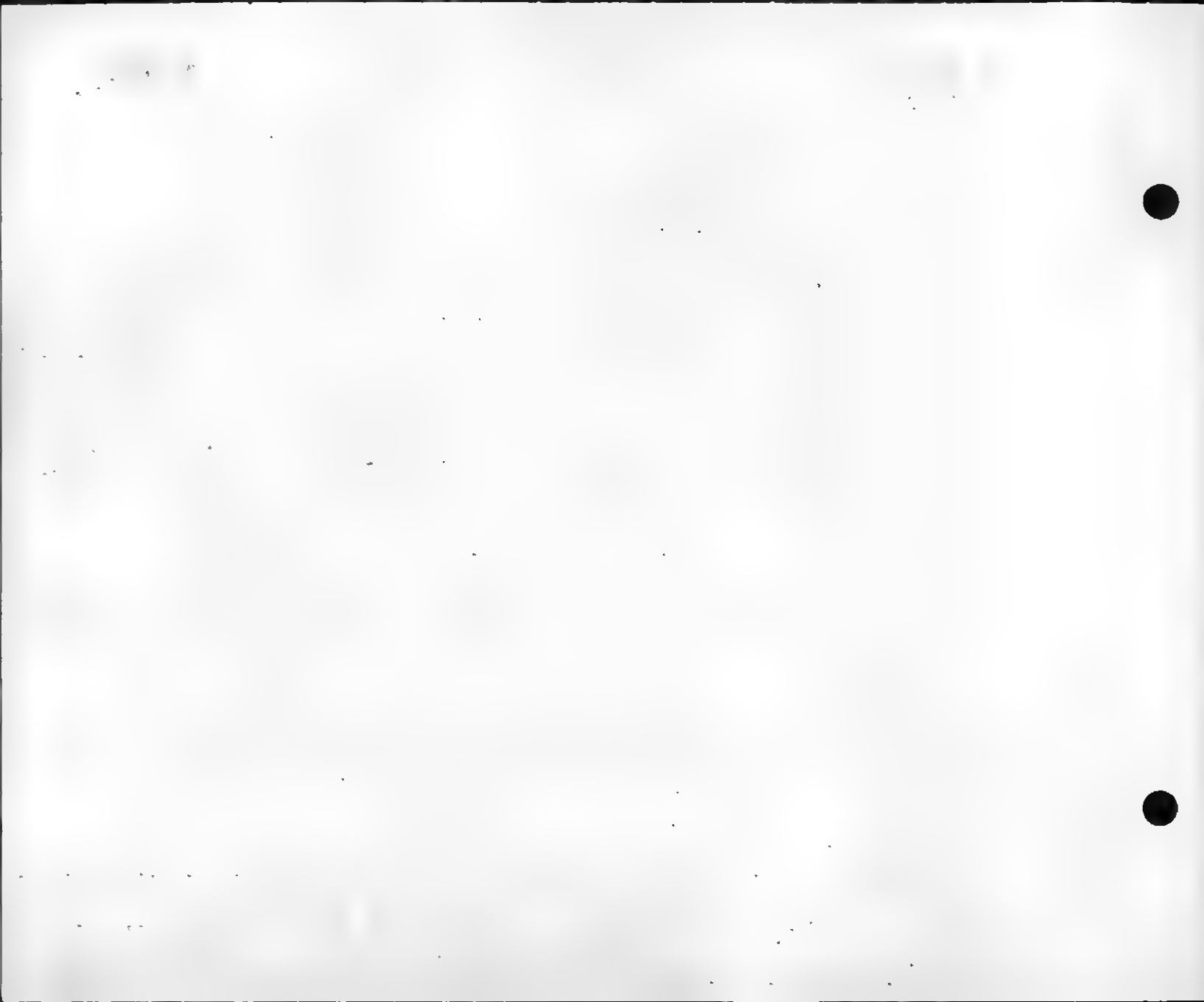
## CERTIFICATE OF DEATH

14487

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>9 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2 USUAL RESIDENCE (Where deceased lived, if institut on Res dence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8 Parkside Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Amelia Bertha Walker</u>		4 DATE OF DEATH Month Day Year <u>October 19 19 66</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-26-95</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11 BIRTHPLACE (County & State, or foreign country) <u>Illinois</u>
13 FATHER'S NAME <u>Adolph Ramseyer</u>		14 MOTHER'S MAIDEN NAME <u>Elizabeth <del>xxxx</del> Johns</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u> <u>None</u>		16 SOCIAL SECURITY NO <u>None</u>	17 INFORMANT <u>Stanton Walker</u> <u>8 Parkside Rd.</u> <u>Silver Spring, Md.</u>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>15 yrs.</u> <u>20 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1964</u> to <u>Oct. 19, 1966</u> that (I) (we) last saw the deceased alive on <u>Oct. 19, 1966</u> , and that death occurred at <u>11 P.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph H. Watson</u>		22b. DATE SIGNED <u>Oct 19, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph H. Watson</u>		22d. ADDRESS <u>3201 Wisconsin Ave., N. W., Wash., D.C.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 22, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>
24 FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

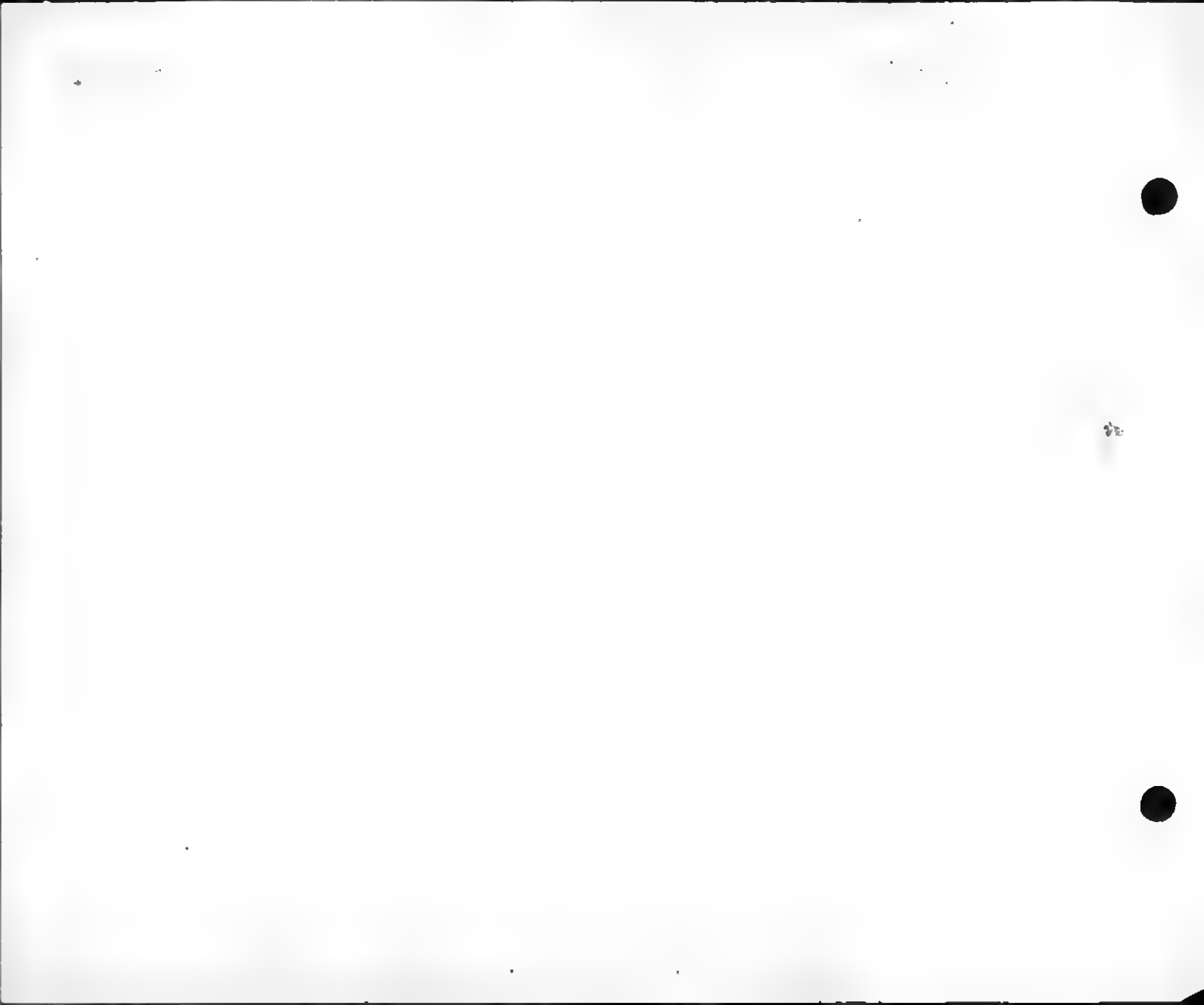
14488

14488

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit if it is used on pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, first listed on Residence before admission) a STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c LENGTH OF STAY IN 1b <u>9 Mo.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>261 Congressional Lane. apt 710</u>		d. STREET ADDRESS <u>apt 710</u> <u>261 Congressional Rd</u>	
3 NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>B.</u> Last <u>Wattus</u>		DATE OF DEATH Month <u>Oct.</u> Day <u>15</u> Year <u>1966</u>	
5 SEX <u>Male</u>	COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <u>3/5/37</u>
9 AGE (In years last birthday) <u>29</u> yrs		IF UNDER 1 YEAR Months <u>29</u> Days <u>29</u> Hours <u>29</u> Min. <u>29</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electronic Tech</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11 BIRTHPLACE (State or foreign country) <u>USA</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Sidney G. Wattus</u>		14 MOTHER'S MAIDEN NAME <u>Ruby</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <u>Brother</u> <u>Lawrence Wattus</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of Heart -</u> <u>X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Gun Shot Wound of Heart.</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) - <u>Shot Salt in chest - 22cal. Revolver -</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:15 a.m. 10/15 1966</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>apartment -</u>	20f (City or town) (County) (State) <u>Rockville Mont Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.		22. DATE SIGNED 10/15/66	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>10/17/66</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Prince Georges, Maryland</u>	
24 FUNERAL DIRECTOR <u>Wilhelm Funeral Home</u> <u>4308 Suitland Rd. Suitland, Md.</u>		25a REC'D BY REGISTRAR <u>OCT 20 1966</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14489 CERTIFICATE OF DEATH 14489											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Potomac</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Potomac Manor Nursing Home</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Echo Hgts.</u> d. STREET ADDRESS <u>5104 Wehauken Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Roscoe</u> First <u>C.</u> Middle <u>Waters</u> Last			4. DATE OF DEATH Month <u>Oct.</u> Day <u>23</u> Year <u>1966</u>								
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-10-81</u>		9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Teaching</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pa.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Francis P. Waters</u>						14. MOTHER'S MAIDEN NAME <u>Katherine E. Palm</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Ruth E. Rinehart</u>			Address <u>Rockville, Md. 4415 France Court</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Emilia</u> DUE TO (b) <u>Nephrosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>Two weeks</u> <u>several years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Double pneumonia secondary to aspiration</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1966</u> , to <u>Oct 23, 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct 23 1966</u> , and that death occurred at <u>11 P.</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Marvin Wadler</u>						22b. DATE SIGNED <u>Oct 24, 1966</u>					
22c. PHYSICIAN'S NAME (Type) <u>Marvin Wadler</u>						22d. ADDRESS <u>8218 Wisc. Ave. Bethesda, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Oct. 27, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>			23d. LOCATION (City, town or county) (State) <u>Pp. Geo. Co., Md.</u>				
24. FUNERAL DIRECTOR <u>W.W. Chambers Co.</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
ADDRESS <u>8655 Gx. Ave., Silver Spring, Md.</u>						DATE <u>OCT 26 1966</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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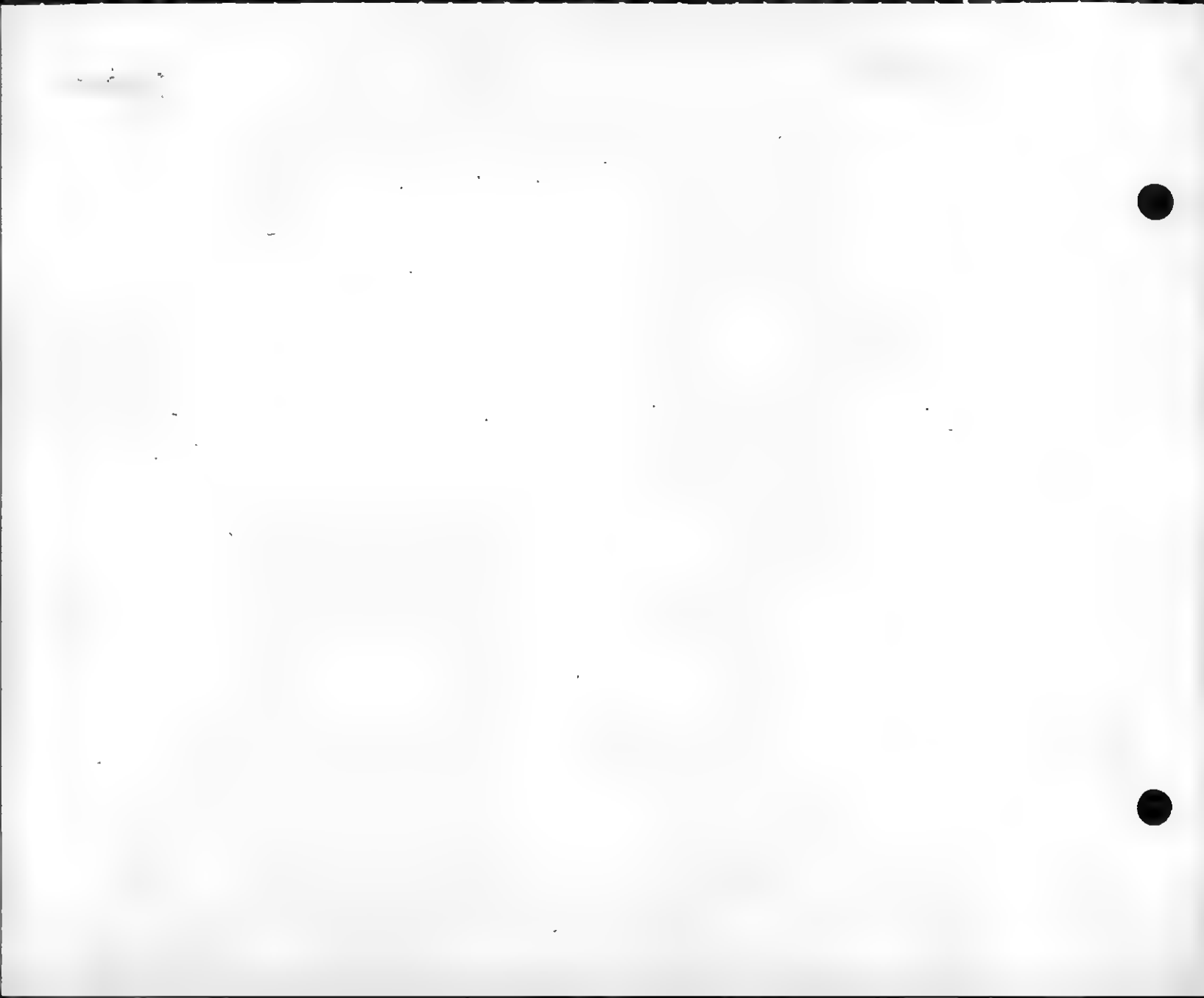
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14490

CERTIFICATE OF DEATH

14490

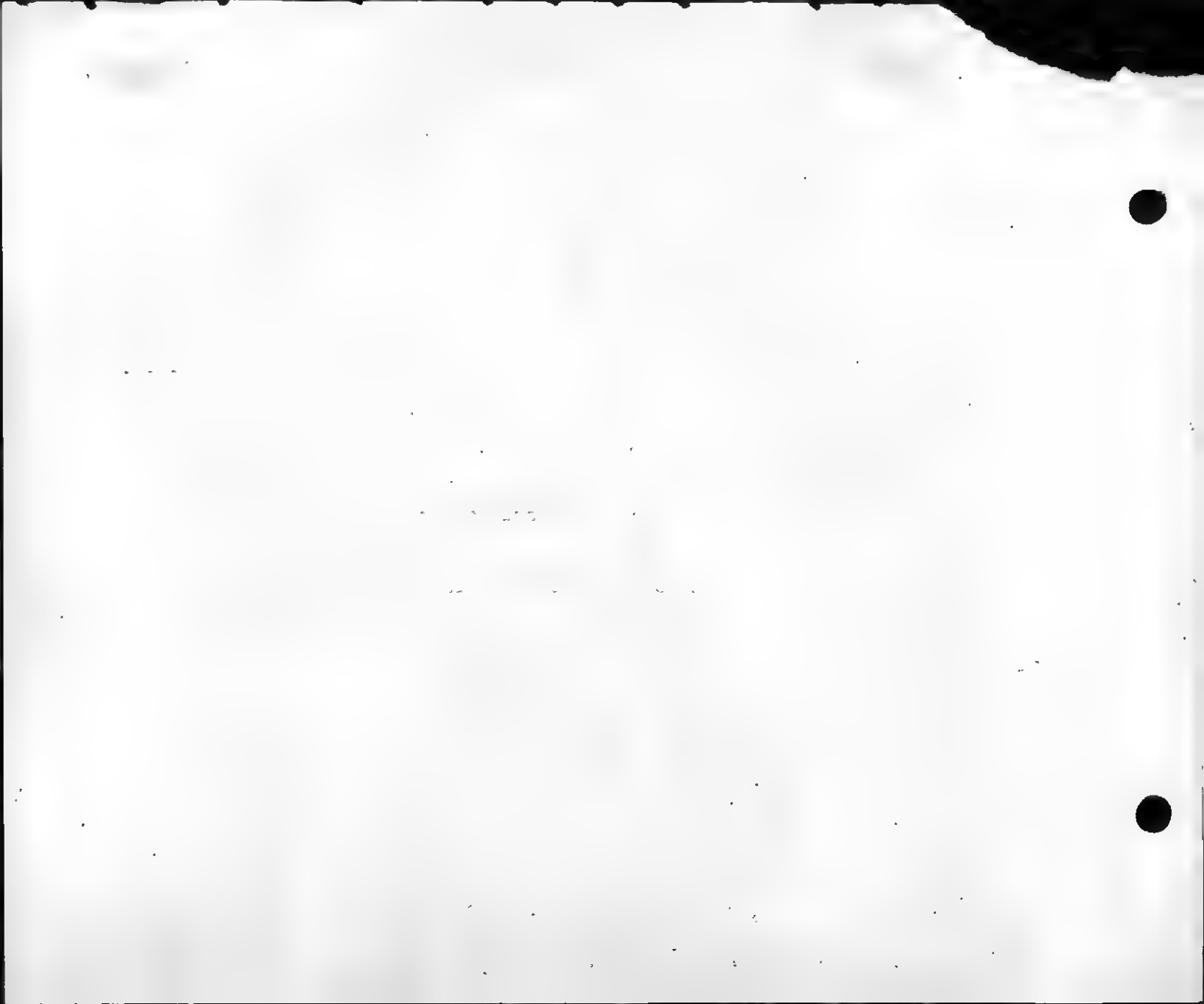
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>28 to 35 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>30 Moore Drive</u>	
3 NAME OF DECEASED (Type or print) First <u>Stephanie</u> Middle <u>E</u> Last <u>Waters</u>		4. DATE OF DEATH Month <u>10</u> Day <u>17</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/26/66</u>
9. AGE (In years last birthday) yrs. <u>4 1/2</u>		10. IF UNDER 1 YEAR Months <u>4 1/2</u> Days <u></u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life (even if retired))		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Robert Staters</u>		14. MOTHER'S MAIDEN NAME <u>Louis E. Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u></u>	
17. INFORMANT <u>Robert Staters</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> <u>492X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Laryngo-Tracheo-Pneumonitis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-17-</u> , 19 <u>66</u> , to <u>10-17-</u> , 19 <u>66</u> ; that (I) (we) last saw the deceased alive on <u>10-17-</u> , 19 <u>66</u> , and that death occurred at <u>3:45</u> PM, from causes on and on the date stated above.			
22a. SIGNATURE <u>Frank M. M. Jr.</u>		22b. DATE SIGNED <u>10/17/66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Robert L. ...</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>NOV 2 1966</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14491						14491					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)					
a. COUNTY <u>MONTGOMERY</u> MARYLAND						a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>					
c. LENGTH OF STAY IN 1b <u>1 MONTH</u>						d. STREET ADDRESS <u>10615 DUNKIRK DRIVE</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>HERMAN</u> First <u>AL</u> Middle <u>ARMSTEAD</u> Last <u>WEAVER</u>						4. DATE OF DEATH <u>10</u> Month <u>29</u> Day <u>19</u> Year <u>66</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/10/26</u>		9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Violin Maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Violins</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alphens Weaver</u>						14. MOTHER'S MAIDEN NAME <u>Mary A. Williams</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>218-12-0035A</u>		17. INFORMANT <u>Jack Weaver</u> Address <u>4116 Great Oak Road Rockville, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASHD</u>											
(c) <u>Chronic pyelonephritis</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>66</u> , to <u>Oct 29</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct 29</u> , 19 <u>66</u> , and that death occurred at <u>9:45</u> A.M., from the causes and on the date stated above.											
22a. SIGNATURE <u>Bernard A. Fitzgerald</u>						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-29-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>						22d. ADDRESS <u>217 UNIV. BLVD E SILVER SP. MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Nov 1, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lakeview Memorial Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Clark E. Wilson</u>				ADDRESS <u>8434 Georgia Avenue</u>				25a. REC'D BY REGISTRAR <u>Warner E. Pumphrey, Inc.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>NOV 2</u>				19 <u>66</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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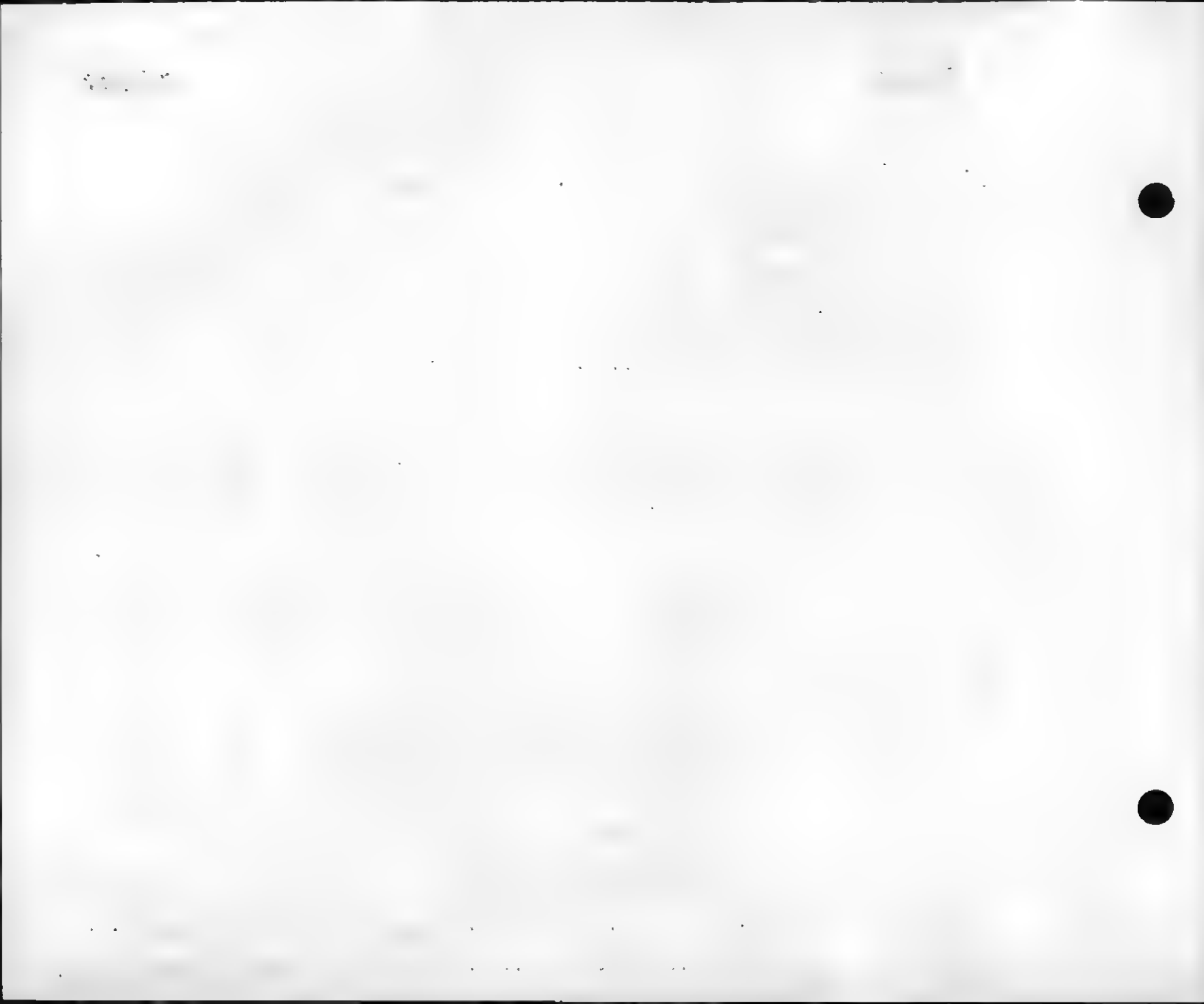
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14492

CERTIFICATE OF DEATH

14492

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institutor on Residence before admission) a. STATE <b>New York</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		c. LENGTH OF STAY IN lb <b>16 mos.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>University Nursing Home</b>		d. STREET ADDRESS <b>3048 Bedford Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Anna none Weinberg</b>		4. DATE OF DEATH Month Day Year <b>10 - 12 - 1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>unknown</b>
8a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		8b. KIND OF BUSINESS OR INDUSTRY -----	
9. AGE (In years last birthday) <b>90</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>? Reistapefel</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Gertrude Geier, see 2 above</b>		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>years</b>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June, 1965</b> , to <b>10 - 1966</b> , that (I) (we) last saw the deceased alive on <b>10-11-1966</b> , and that death occurred at <b>9:20 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Irwin H. Ardani, M.D.</b>		22b. DATE SIGNED <b>10-12-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>IRWIN H. ARDANI, M.D.</b>		22d. ADDRESS <b>1712 - I - St, N.W., WASH., D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10-14-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hebron Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Flushing, Queens, N.Y.</b>
24. FUNERAL DIRECTOR <b>Goldberg's - 4217 9th St., N. W., Wash., D. C.</b>		25a. REC'D BY REGISTRAR <b>OCT 14 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14493

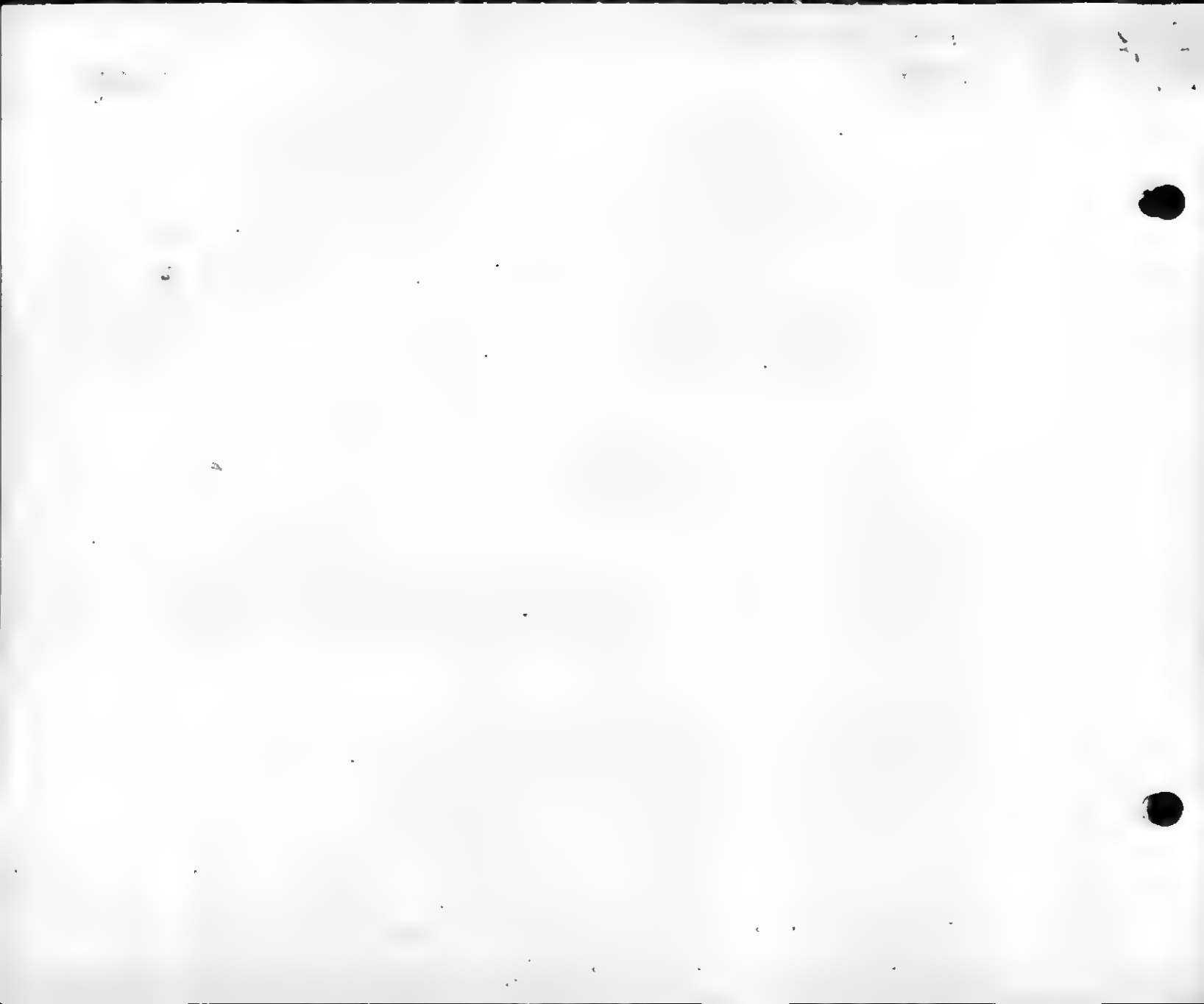
## CERTIFICATE OF DEATH

14493

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>DERWOOD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		d. STREET ADDRESS <u>17809 VINEYARD LANE</u>	
3 NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>C</u> Last <u>WETMORE</u>		4 DATE OF DEATH Month <u>October</u> Day <u>3</u> Year <u>1966</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-7-1889</u>
9 AGE (In years last birthday) <u>77</u> yrs		10 IF UNDER 1 YEAR Months <u>3</u> Days <u>25</u> Hours <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>BUFFALO N.Y.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>August DREWS</u>		14. MOTHER'S MAIDEN NAME <u>MINNIE SCHULTZ</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO. <u>Unknown</u>	
17 INFORMANT (Name) <u>FRANK WETMORE</u> Address <u>1941 Indian Ave Vallejo, California</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>			
DUE TO (b) <u>acute Blast Leukemia</u>			
DUE TO (c) <u>Chronic Myelo Monocyte Leukemia</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-19</u> , 19 <u>66</u> , to <u>Oct 3</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct 2</u> , 19 <u>66</u> , and that death occurred at <u>6a</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>William H. Killay</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>October 3, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>William H. Killay</u>		22d. ADDRESS <u>8218 Wisconsin Avenue, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>	23b. DATE THEREOF <u>Oct. 3, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Springfield Massachusetts</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 7 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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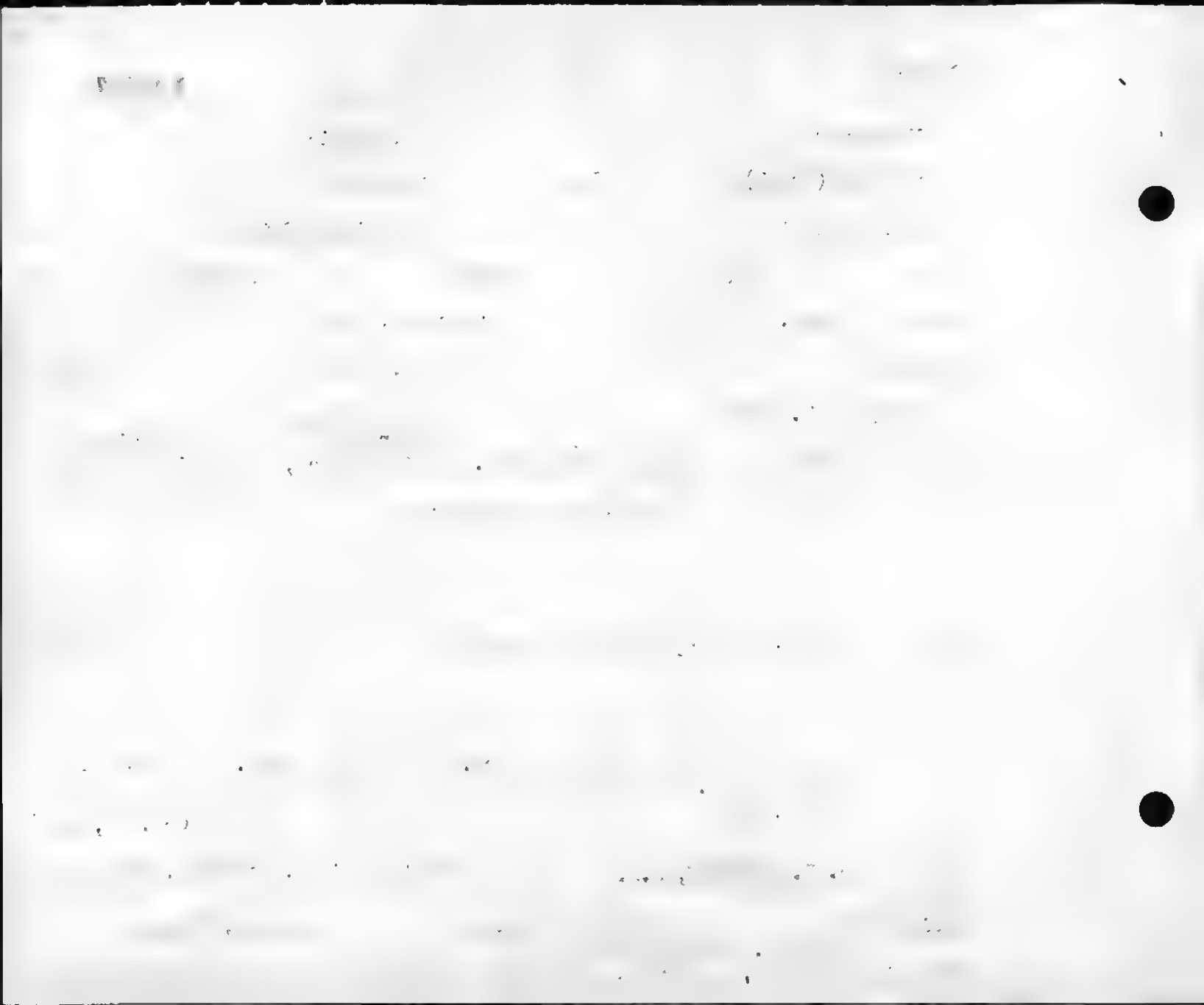
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14494

CERTIFICATE OF DEATH

14494

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annandale</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>4911 Bristow Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Alma</b> Middle <b>WHEELER</b> Last		4 DATE OF DEATH Month <b>October</b> Day <b>31</b> Year <b>19 66</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>August 21, 1893</b>
9 AGE (In years last birthday) <b>73</b> yrs		IF UNDER YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Vernon, Texas</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William E. WEST</b>		14 MOTHER'S MAIDEN NAME <b>Jennie Capps</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No N/A</b>		16. SOC. A. SECURITY NO <b>465 54 0010</b>	
17 INFORMANT <b>Annandale</b> Address <b>Virginia</b> <b>Mrs. Gloria Wineman, 4911 Bristow Drive</b>			
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cancer of the breast with widespread metastases</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>44</b> (this hospital) attended the deceased from <b>Oct. 25</b> , 19 <b>66</b> , to <b>Oct. 31</b> , 19 <b>66</b> that <b>49</b> (we) last saw the deceased alive on <b>Oct. 31</b> , 19 <b>66</b> , and that death occurred at <b>655A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>H. E. Ashworth</b>		22b. DATE SIGNED <b>Oct. 31, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. E. ASHWORTH, M.D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 11-1-66</b>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Orange, Texas</b>
24 FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>NOV 1 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and no later than 72 hours after death.

VR A15ME (5)  
6M 1/66

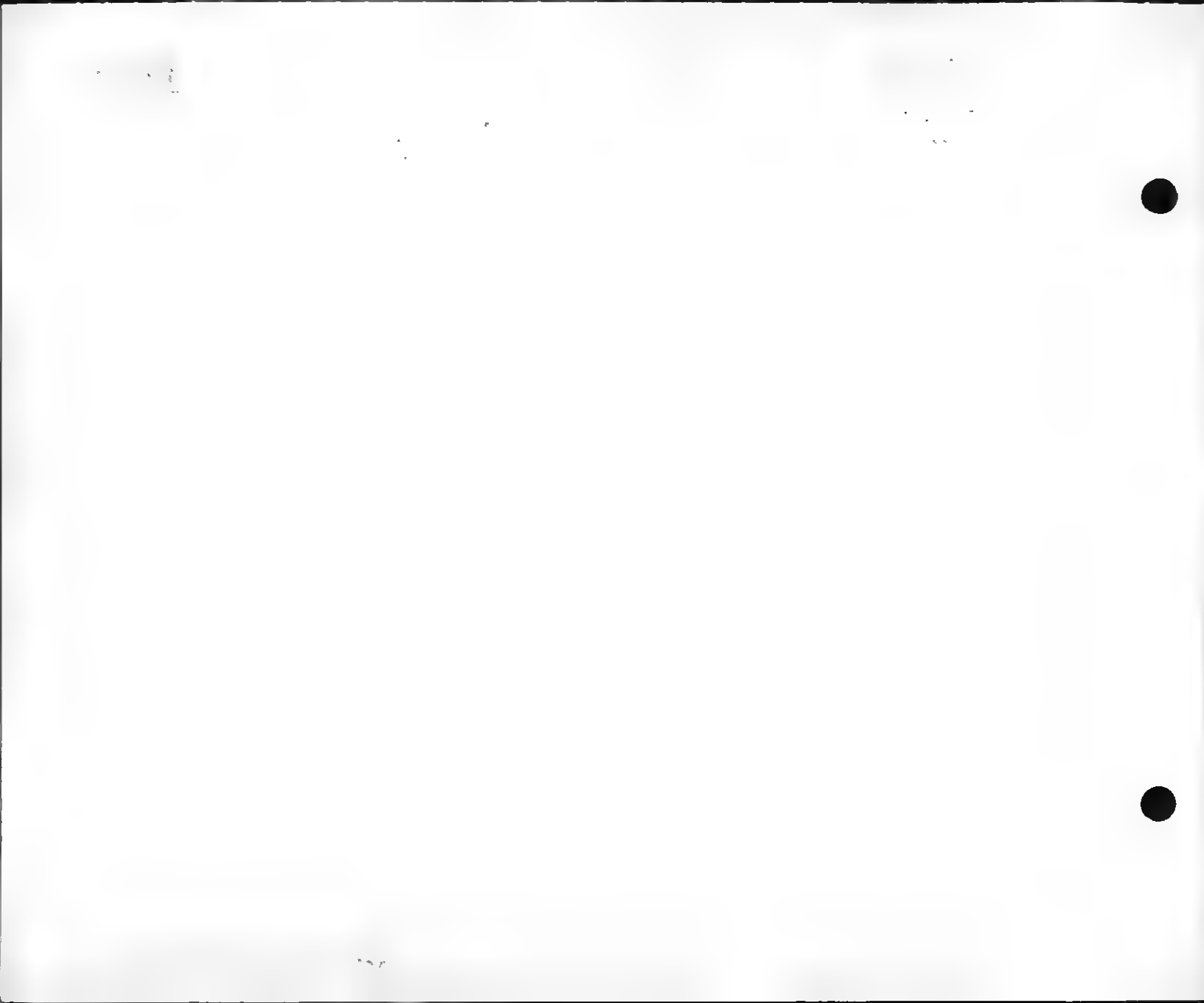
FOR STATE  
HEALTH DEPT

14495

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14495

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tal, give street address) <u>Wash Saint Hospital</u>				d. STREET ADDRESS <u>7804 Carroll Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clinton</u> First <u>g.</u> Middle <u>Wigle</u> Last				4. DATE OF DEATH Month <u>10</u> Day <u>3</u> Year <u>1966</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-20-97</u>		9. AGE (In years last birthday) <u>69</u> Yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Wigle</u>				14. MOTHER'S MAIDEN NAME <u>Miriam Hill</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv) <u>yes</u> <u>W.W.I</u>		16. SOCIAL SECURITY NO <u>128-12-6261</u>		17. INFORMANT Address <u>Edra Wigle (sister)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> <u>4x111</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery heart disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Oct 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
24. FUNERAL DIRECTOR <u>Charles Judge</u>				25a. REC'D BY REGISTRAR <u>OCT 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
23d. LOCATION (City or town) <u>Arlington</u>				23e. (County) <u>Virginia</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

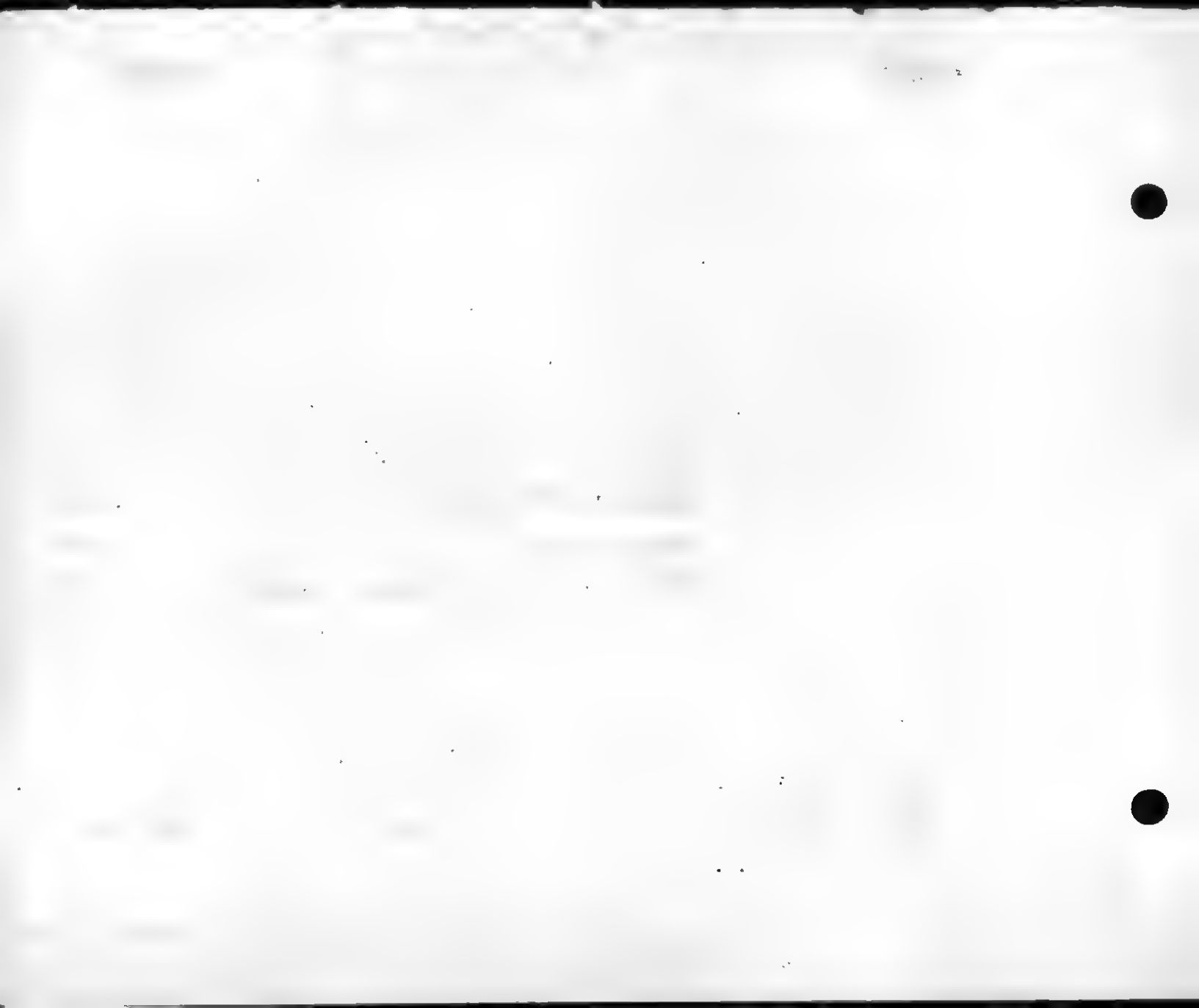
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

14496

14496

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DERWOOD</u>				c. LENGTH OF STAY IN IB <u>63-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7112 HUNCASTER MILL RD</u>				d. STREET ADDRESS <u>115 MELVIN AVE</u>			
3. NAME OF DECEASED (Type or print) First <u>BLANCHE</u> Middle <u>M.</u> Last <u>WILHELM</u>				4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>27</u> Year <u>1966</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 3, 1896</u>	
				9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL CAFETERIA</u>		11. BIRTHPLACE (County & State, or foreign country) <u>JAPAN</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JAMES T. MYERS</u>				14. MOTHER'S MAIDEN NAME <u>SUSIE BROOKS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>215-34-7505</u>		17. INFORMANT <u>Richard D. Walden - 7101 Mount Pleasant Mill Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PNEUMONITIS</u> DUE TO (c) <u>CARCINOMATOSIS - PRIMARY IN BREAST</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 HRS</u> <u>2 WKS</u> <u>5 MOS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>14 SEPT. BEG. 1966</u> , to <u>27 OCTOBER 1966</u> , that (I) (we) last saw the deceased alive on <u>27 OCTOBER 1966</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Ronald W. Barr</u>				22b. DATE SIGNED <u>28 OCTOBER 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>RONALD W. BARR, M.D.</u>				22d. ADDRESS <u>1601 Federal Ave. #2</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-31-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Woodlawn MD.</u>	
24. FUNERAL DIRECTOR <u>John Carrington</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14497

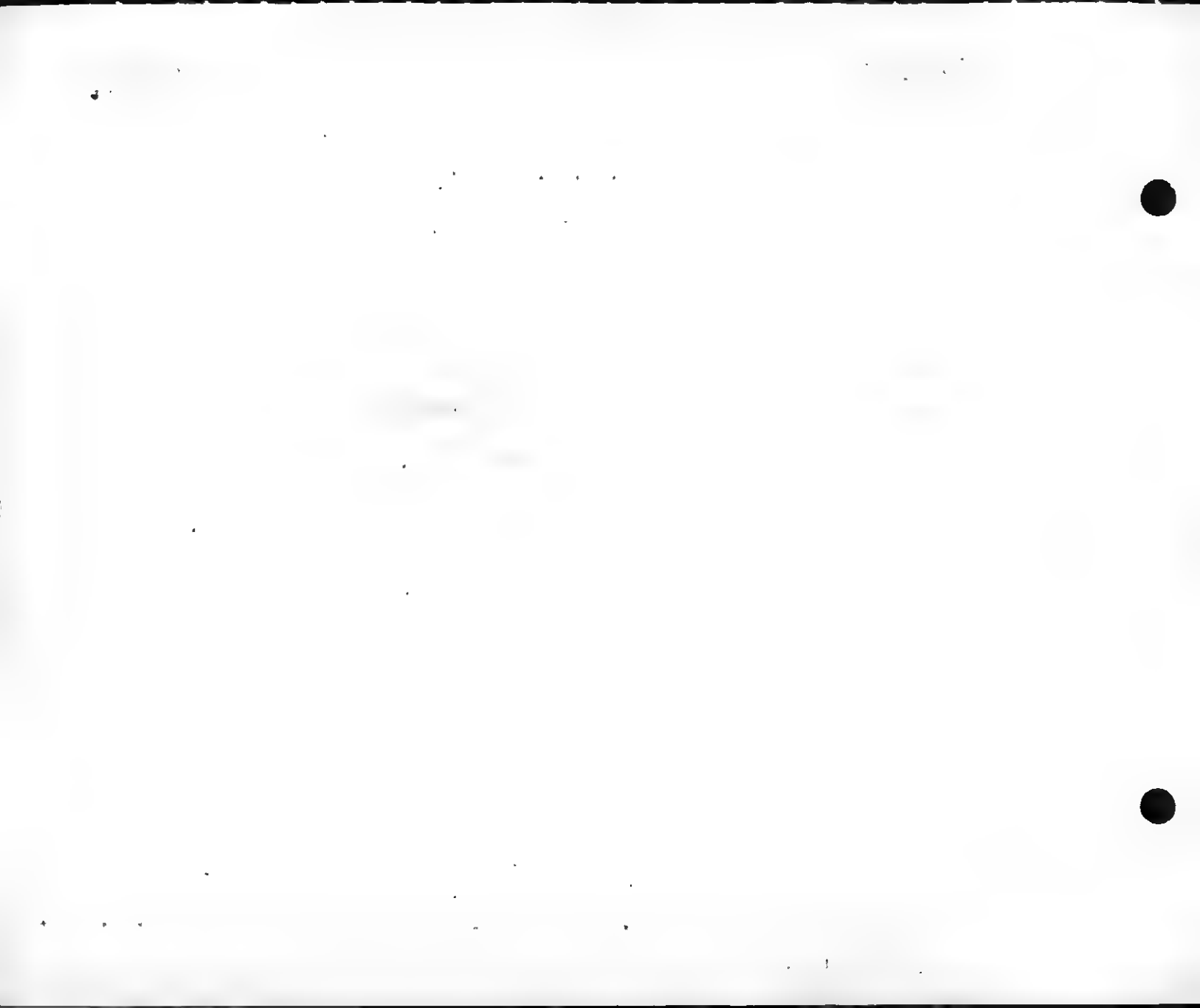
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14497

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>D. O. A.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS <u>7969 18th Ave.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Lawrence</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>October</u> Day <u>15</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 13, 1901</u>
9. AGE (In years last birthday) <u>65</u> yrs		IF UNDER 1 YEAR Months <u>6</u> Days <u>5</u>	IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail - Clothing</u>	11. BIRTHPLACE (State or foreign country) <u>D. of C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>CHARLES WILLIAMS</u>	
14. MOTHER'S MAIDEN NAME <u>MARIE VERSADE</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO <u>577-10-2545</u>		17. INFORMANT <u>LUCILLE E.</u> Address <u>7969 18th Ave. (WIFE)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>421</u> DUE TO <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary Artery Heart Disease</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Months, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accidents <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		22. DATE SIGNED <u>Oct. 15, 1966</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10/18/66</u>	23c. NAME OF CEMETERY OR PLACE OF BURIAL <u>FT. LINCOLN CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>COLMAR MANOR P. G. Md.</u>
24. FUNERAL DIRECTOR <u>FRANCIS GASCH'S SONS</u> ADDRESS <u>HYATTSVILLE, MARYLAND</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 18 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14498

CERTIFICATE OF DEATH

14498

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>3 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HECHY CHASE NURSING HOME</u>		d. STREET ADDRESS <u>5522 OAK PLACE</u>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>C.</u> Last <u>WINTERS</u>		4 DATE OF DEATH Month <u>10</u> Day <u>6</u> Year <u>1966</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-31-85</u>
9 AGE (In years last birthday) <u>80</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Boston, Mass.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Preble</u>		14. MOTHER'S MAIDEN NAME <u>L. Mary Austin</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <u>Shirley Van Buren</u>		Address <u>5522 Oak Pl.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE BREAST</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-28</u> , 19 <u>66</u> , to <u>10-6</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>10-6</u> , 19 <u>66</u> , and that death occurred at <u>3 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Richard H. Pollen</u> M.D.		22b. DATE SIGNED <u>10-6-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLEN MD</u>		22d. ADDRESS <u>10400 CONNECTICUT AVE, KENSINGTON MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct 9, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Belmonton Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Belmonton New Hamp</u>
24 FUNERAL DIRECTOR <u>J. Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>254 Canal St.</u> DATE <u>OCT 10 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*Charles E. Dr. B. Reap & Michael McGuffey, M.D.*

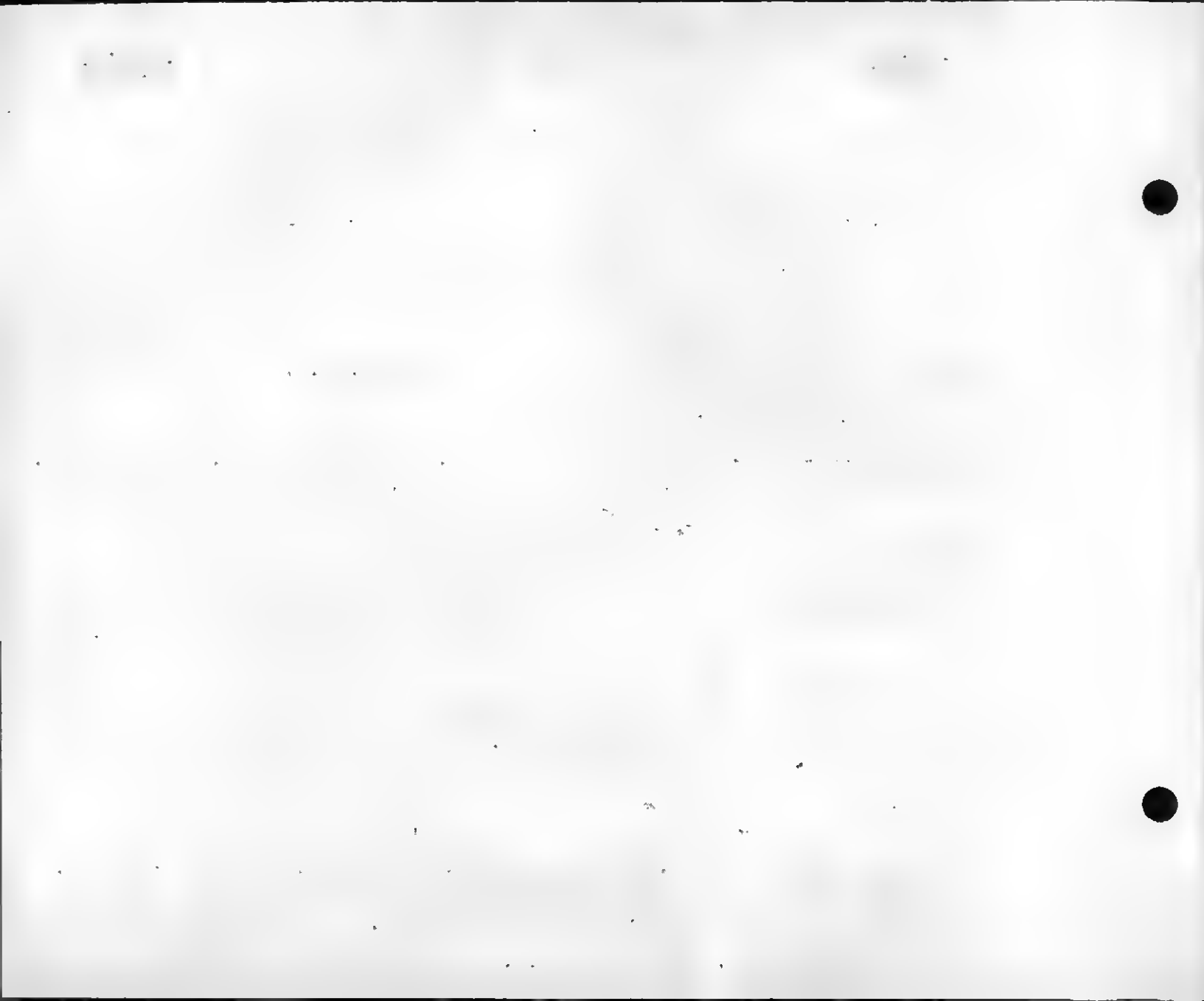
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14499

CERTIFICATE OF DEATH

14499

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY in lb <u>10</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>1804 East West Hwy.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>Gordon Peter Wojciak</u>		4 DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>Cauc</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7/4/64</u>
9 AGE (in years last birthday) <u>2</u> yrs.		10 IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	11 IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Adam John Wojciak</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Rutan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Father, 5209 Chandler St, Bethesda, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Arrest.</u> <u>1543</u> DUE TO (b) <u>Brain Damage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Congenital + Anoxic Episode.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>July 4, 1964</u> to <u>OCT 15, 1966</u> , that (I) (we) last saw the deceased alive on <u>OCT 15, 1966</u> , and that death occurred at <u>11:20 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Ralph Stiller</u>		22b. DATE SIGNED <u>OCT 15, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ralph Stiller, MD</u>		22d. ADDRESS <u>1110 Spring St, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/19/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Washington, D.C.</u>		25a. REC'D BY REGISTRAR OATE <u>OCT 19 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14500

14500

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Etchison</b> c. LENGTH OF STAY IN 1b <b>15 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt. #2 Etchison (Gaithersburg)</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Grant</b> Middle <b>E.</b> Last <b>Woodfield</b>			4. DATE OF DEATH Month <b>October</b> Day <b>4</b> Year <b>1966</b>		
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>May 30, 1874</b>		9. AGE (In years last birthday) <b>92</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Edward Woodfield</b>		
14. MOTHER'S MAIDEN NAME <b>Sarah Ann Burns</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		
16. SOCIAL SECURITY NO. <b>220-48-0811</b>			17. INFORMANT <b>Mrs. Mamie Burns</b> Address <b>Same as 2</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis cardiovascular disease</b> (b) <b>Cerebral thrombosis</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (b) <b>Cerebral thrombosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/1/13</b> to <b>10/4/66</b> that (I) (we) last saw the deceased alive on <b>8/7/66</b> , and that death occurred at <b>10/4/66</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <b>James P. Kerr</b> M.D.			22b. DATE SIGNED <b>10-4-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>James P. Kerr M.D.</b>			22d. ADDRESS <b>Damascus, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-6-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Damascus</b>	
23d. LOCATION (City, town or county) <b>Damascus, Md.</b>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b> ADDRESS <b>Laytonsville, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>OCT 2 1966</b>		
25b. REGISTRAR'S SIGNATURE <b>John J. Lee</b>					

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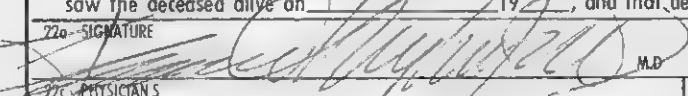
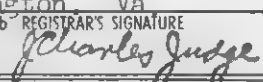
# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

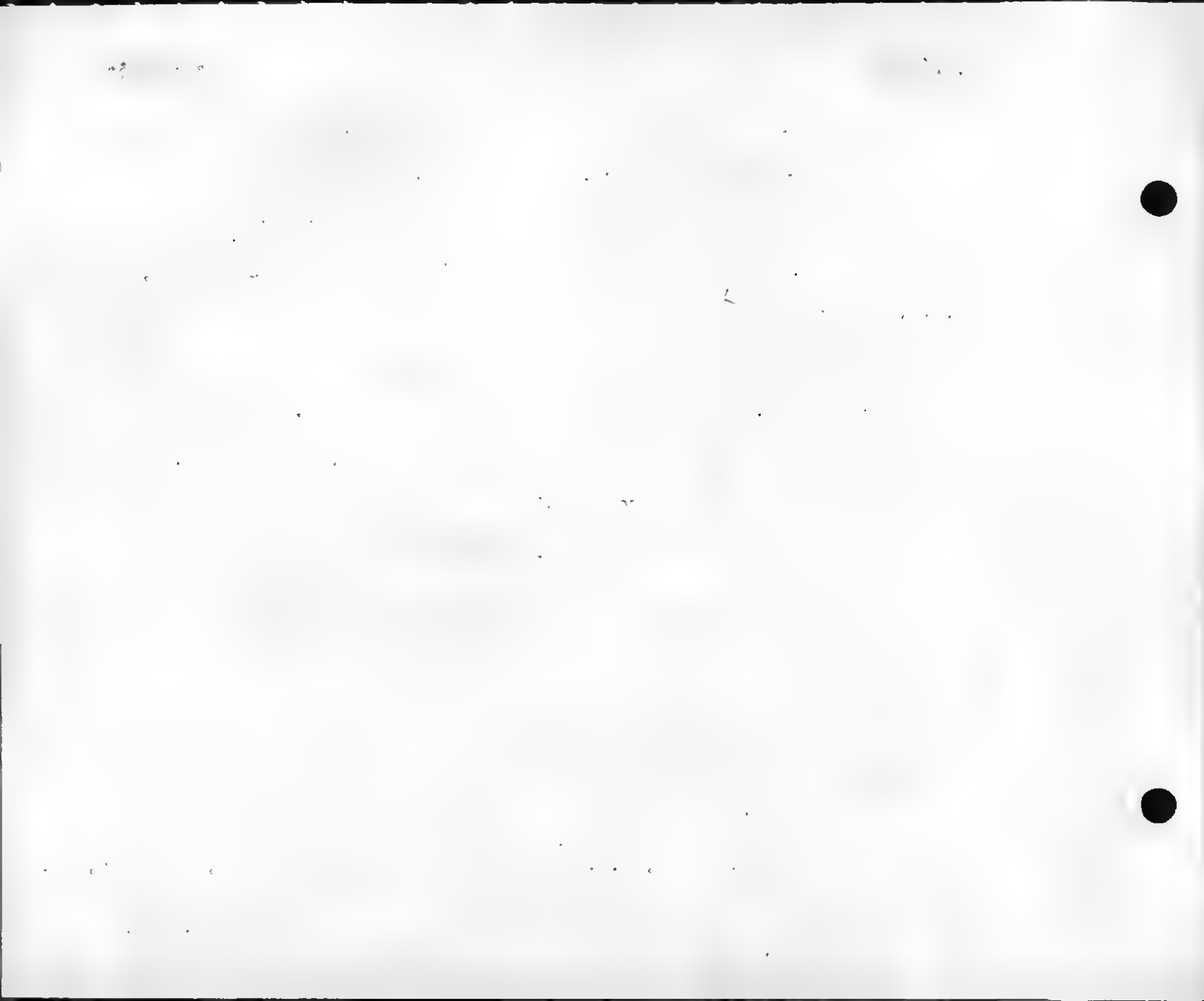
**14501**

## CERTIFICATE OF DEATH

**14501**

<b>1 PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>2 mos.</b>		<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>16409 Henry Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3 NAME OF DECEASED</b> (Type or print) First Middle Last <b>Carol Anne Workinger</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>October 19, 19 66</b>	
<b>5 SEX</b> <b>Female</b>	<b>6 COLOR OR RACE</b> <b>White</b>	<b>7 MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8 DATE OF BIRTH</b> <b>10/7/63</b> <b>9. AGE</b> (In years last birthday) <b>3</b> yrs. f. UNDER 1 YEAR <input type="checkbox"/> g. UNDER 24 HRS. <input type="checkbox"/>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	
<b>11 BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>		<b>12 CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>	
<b>13. FATHER'S NAME</b> <b>Theodore R. Workinger</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Elaine M. Erickson</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	
<b>17 INFORMANT</b> <b>Theodore R. Workinger. As #2</b>		Address	
<b>18. CAUSE OF DEATH</b> (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Sarcomatosis</b> 1979 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Palatine fibrosarcoma</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
<b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b>  <b>22c. PHYSICIAN'S NAME (Type)</b> <b>Francis C. Mayle, M.D.</b>		<b>22b. DATE SIGNED</b> <b>10/19/66</b> <b>22d. ADDRESS</b> <b>8218 Wisconsin Avenue, Bethesda, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>10-24-66</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>	<b>23d. LOCATION (City or Town) (County) (State)</b> <b>Arlington, Va</b>
<b>24. FUNERAL DIRECTOR</b> <b>Ernest C. Gartner</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE OCT 24 1966</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

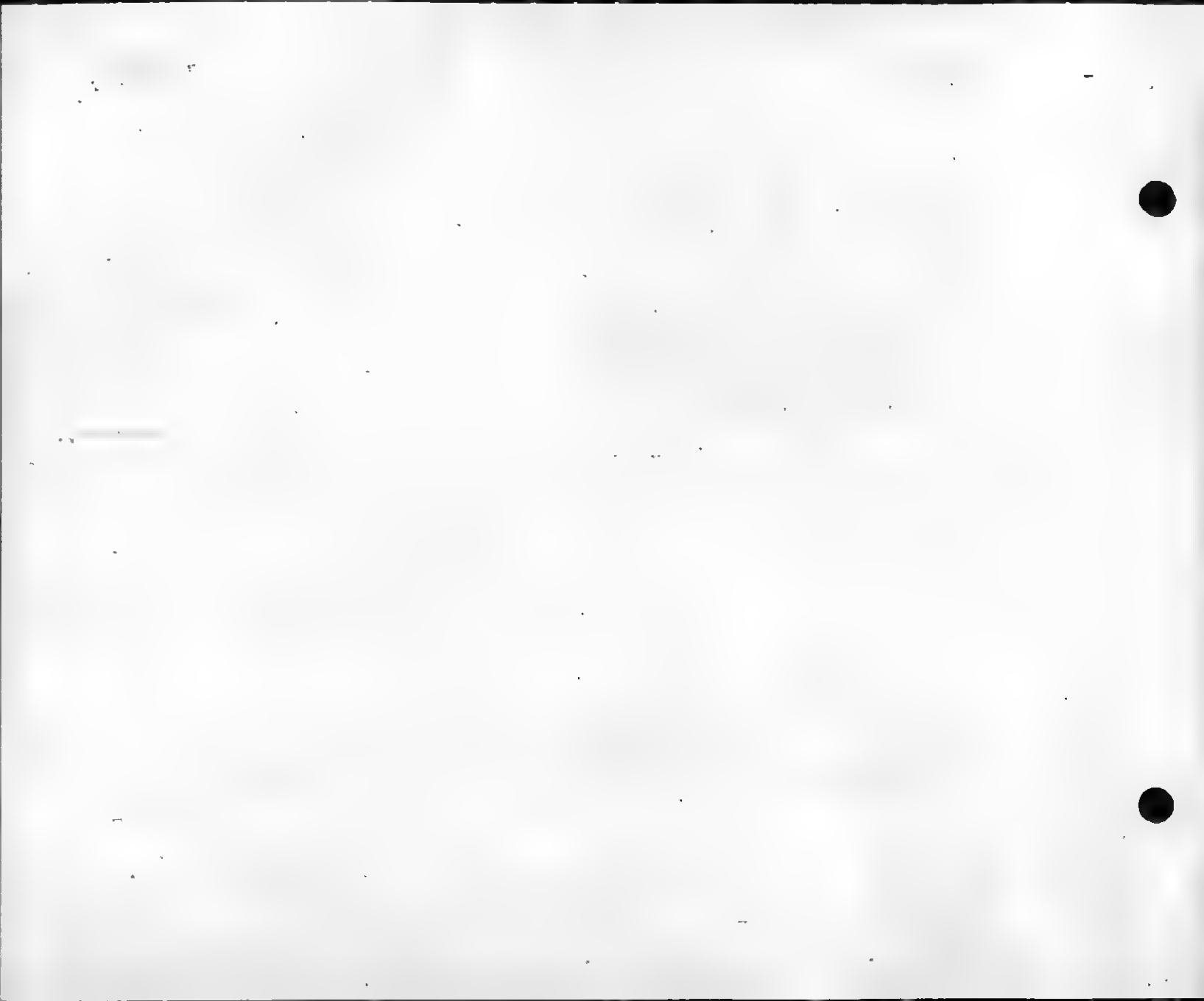
**14502**

**CERTIFICATE OF DEATH**

**14502**

<b>1 PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRINGS</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u> d. STREET ADDRESS <u>2302 BLUE RIDGE AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3 NAME OF DECEASED</b> (Type or print) First Middle Last <u>NETTIE E. WRIGHT</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>10 20 1966</u>	
<b>5 SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>B. DATE OF BIRTH</b> <u>6/25/91</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>MARYLAND</u>	
<b>11 BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u>		<b>12 CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13 FATHER'S NAME</b> <u>Garrett Lethcun</u>		<b>14 MOTHER'S MAIDEN NAME</b> <u>Mary Ann Hillary</u>	
<b>15 WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		<b>16 SOCIAL SECURITY NO.</b> <u>220-42-3809A</u>	
<b>17 INFORMANT</b> <u>Daughter</u>		<b>4105 Sampson Rd.</b> <u>Margaret Barden Silver Spring, Md.</u>	
<b>18 CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Depression</u> DUE TO (b) <u>Uremic coma</u> DUE TO (c) <u>Chronic prerenal kidney disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Minutes</u> <u>Days</u> <u>Months</u>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. _____ 19____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>4/26</u> , 19 <u>64</u> , <b>to</b> <u>10/20</u> , 19 <u>66</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>19</u> , <b>and that death occurred at</b> _____, M, <b>from causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Richard P. Delaney</u> M.D.		<b>22b. DATE SIGNED</b> <u>10-22-66</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>RICHARD P. DELANEY</u>		<b>22d. ADDRESS</b> <u>4323 Harvard St. Silver Spring, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>10-25-66</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Monocacy Cemetery</u>		<b>23d. LOCATION (City or Town) (County) (State)</b> <u>Beallsville, Maryland</u>	
<b>24 FUNERAL DIRECTOR</b> <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14503

## CERTIFICATE OF DEATH

14503

1. PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONT.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c LENGTH OF STAY IN 1b <u>1 yr. 3 mo</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Silvermont Health Care Center</u>		d STREET ADDRESS <u>9300 St Andrews Way</u>	
3. NAME OF DECEASED (Type or print) <u>Yaffe, Sarah</u> First Middle Last		4. DATE OF DEATH <u>Oct 5 1966</u> Month Day Year	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-12-1887</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>LITHUANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>LITHUANIA</u>	
13. FATHER'S NAME <u>AREC YUDELEVIT</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>SIDNEY KLINE SAME AS 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year <u>4:45 p.m. Oct 5 1966</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 1965</u> , to <u>Oct 5, 1966</u> that (I) (we) last saw the deceased alive on <u>7/26</u> 19 <u>66</u> , and that death occurred on <u>Oct 5</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Raymond Scalettar</u> M.D.		22b. DATE SIGNED <u>Oct 5 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>RAYMOND SCALETTAR</u>		22d. ADDRESS <u>2400-H St N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10-9-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>D.C. LODGE CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON D.C.</u>
24. FUNERAL DIRECTOR <u>GOLDBERG FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 10 1966</u>	
ADDRESS <u>4217-94th H.W.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

14504

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14504

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>PENNA.</u> b. COUNTY <u>Northumberland</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>3 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery Conv. Home</u>				d. STREET ADDRESS <u>401 Chestnut St.</u>			
3. NAME OF DECEASED (Type or print) <u>George Jacob Vocum</u>				4. DATE OF DEATH Month <u>October</u> Day <u>30</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-8-1894</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PENNA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>John Vocum</u>			
14. MOTHER'S MAIDEN NAME <u>EMORY</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>unk</u>				17. INFORMANT <u>Mrs. Treon - Daughter, Same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>PULMONARY EDEMA</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ORGANIC BRAIN SYNDROME</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 HRS.</u> <u>3 HRS.</u> <u>YES.</u>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>66</u> to <u>Oct 30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct 30</u> , 19 <u>66</u> , and that death occurred at <u>5:21</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Donald R. Lewis</u>				22b. DATE SIGNED <u>10/30/66</u>		22c. PHYSICIAN'S NAME (Type) <u>DONALD R. LEWIS</u>	
22d. ADDRESS <u>700 CLOVERLY SILVER SPR. MD</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>BURIAL</u>		<u>Nov 3</u>		<u>HARMONY CEM</u>		<u>MILTON, PENNA</u>	
24. FUNERAL DIRECTOR <u>Harold S. Wady, Laurel, Md</u>				25a. REC'D BY REGISTRAR <u>NOV 4 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

14505

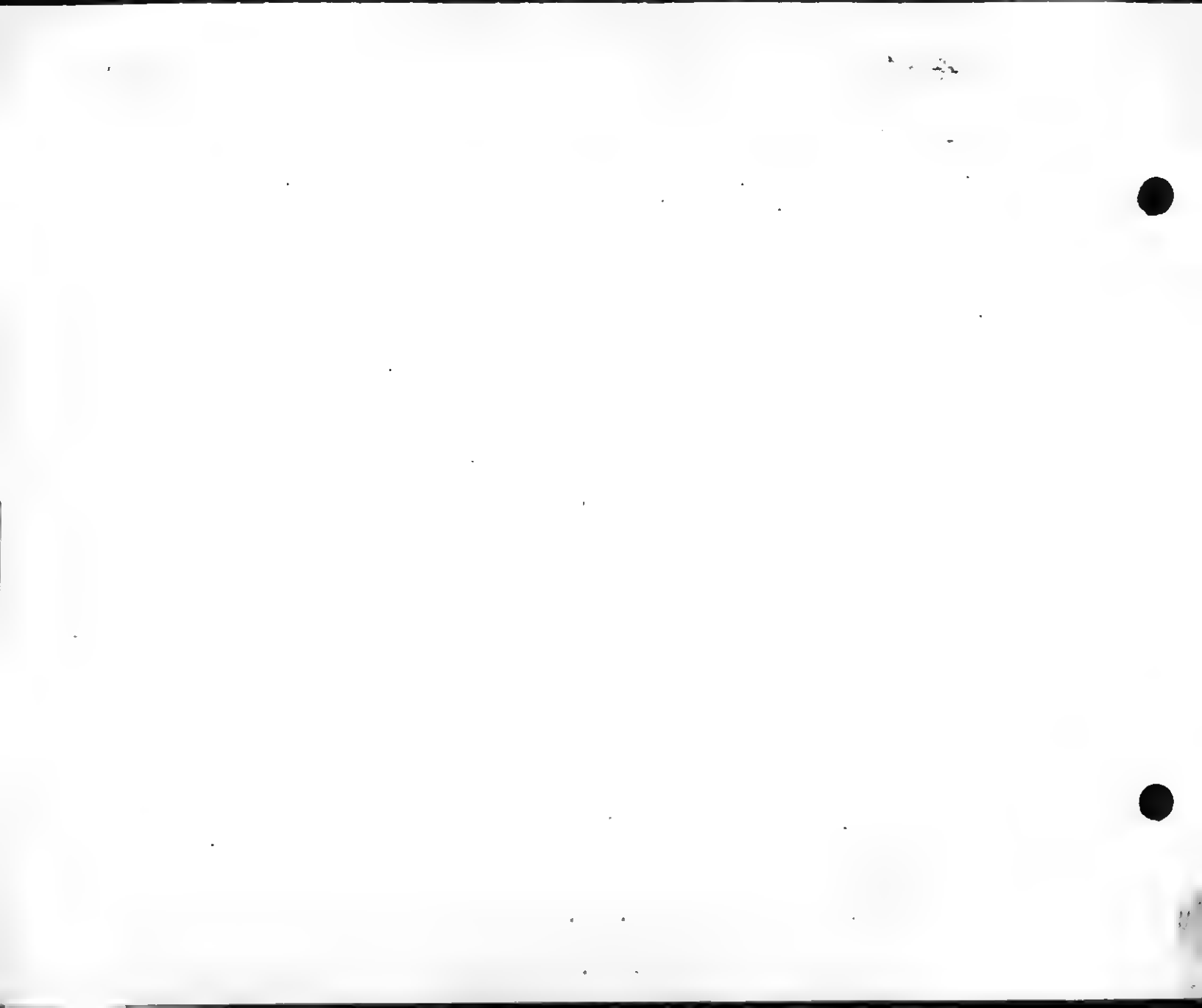
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14505

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to, give street address) <u>12003 Colin Rd.</u>		d. STREET ADDRESS <u>12003 Colin Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Ralph E. Young Jr.</u>		4. DATE OF DEATH Month <u>10</u> Day <u>28</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-18-03</u>
9. AGE (In years last birthday) <u>63</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph E. Young</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>39-10-1651</u>	
17. INFORMANT <u>Ralph Young Jr. - Son</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>445X</u> DUE TO <u>Congestive heart failure due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Hypertensive cardiovascular disease</u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>10/28/1966</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (street, city, town or county) <u>  </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial - Tran.</u>	23b. DATE THEREOF <u>10/29/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. St. Mary's</u>	23d. LOCATION (City or town) (County) (State) <u>Pawtucket, Rhode Island</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 2 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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(M)

14506

UNITED STATES DEPARTMENT OF HEALTH

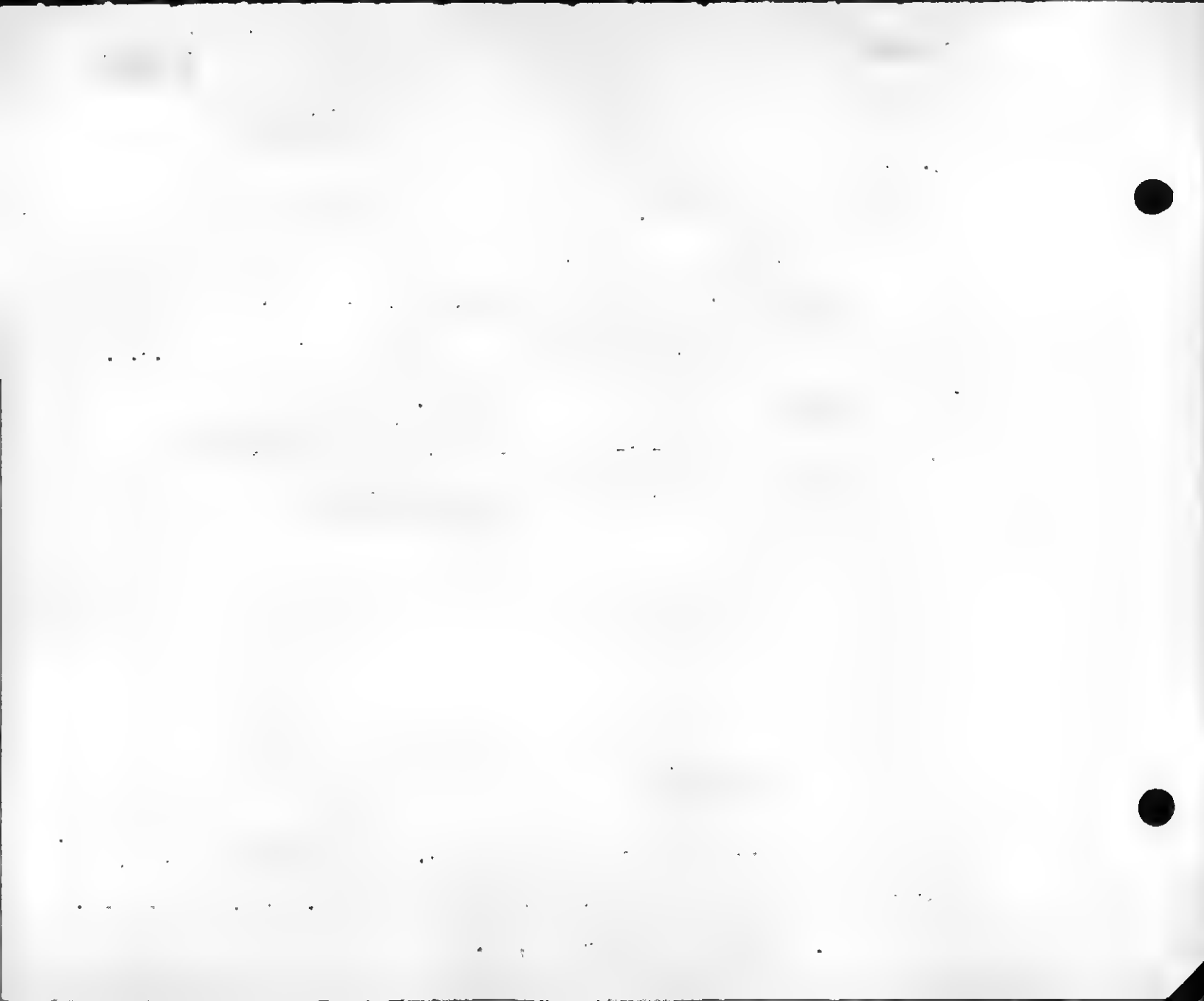
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14506

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>9 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Verona</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>17 Cypress Avenue</b> d. STREET ADDRESS <b>17 Cypress Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>Joseph Edward Zamierowski</b>		4. DATE OF DEATH Month <b>October</b> Day <b>20</b> Year <b>1966</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>27 November 1914</b>		9. AGE (In years last birthday) <b>51 yrs.</b>		10. UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		11. UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Technician</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Manufacturing Firm</b>				11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Thomas Zamierowski</b>				14. MOTHER'S MAIDEN NAME <b>Anna C. Pitera</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>136-01-0164</b>				17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatic Heart Disease with mitral and aortic insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>410X</b> DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH <b>40 years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>p.m.</b> <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 11, 1966</b> , to <b>October 20, 1966</b> , that <b>XIX</b> (we) last saw the deceased alive on <b>October 20, 1966</b> , and that death occurred at <b>9:00 M.</b> , from the causes and on the date stated above.																			
22a. SIGNATURE <b>Alan S. Rosenthal</b>				22b. DATE SIGNED <b>20 October 1966</b>				22c. PHYSICIAN'S NAME (Type) <b>Alan S. Rosenthal, MD</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>10/24/66</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>N. Arlington, N.J.</b>							
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Md.</b>				25a. REC'D BY REGISTRAR <b>OCT 25 1966</b>				25b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>							

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

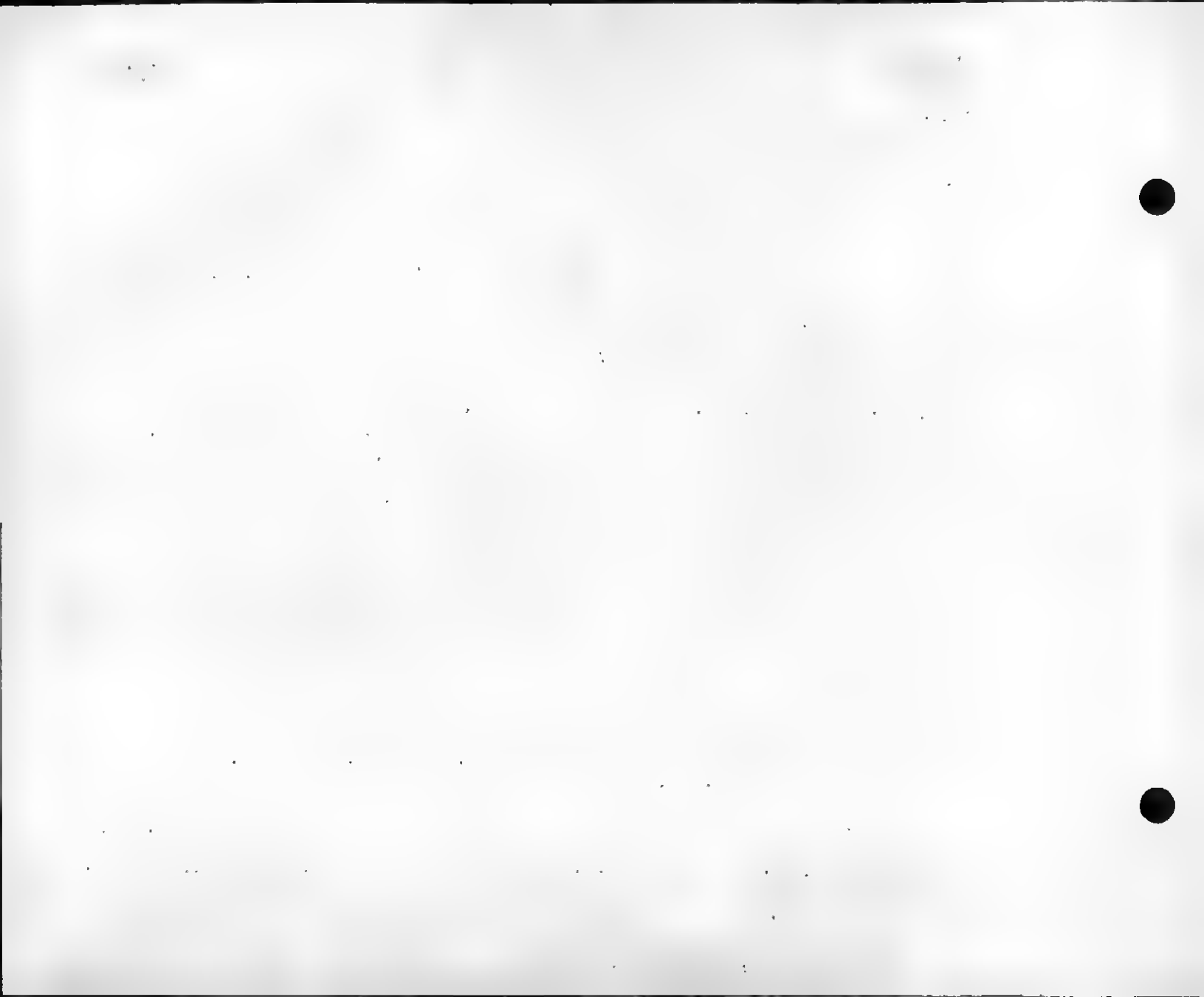
14507

Item #23b Film #4482 10/26/66

CERTIFICATE OF DEATH

14507

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Springfield</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>6441 Northanna Drive</b>	
3 NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Valentine</b> Last <b>ZEBERLEIN III</b>		4 DATE OF DEATH Month <b>October</b> Day <b>13</b> Year <b>19 66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Sept. 24, 1966</b>
9. AGE (In years last birthday) <b>19</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Montgomery, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>George V. Zeberlein, Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Joan Marrie</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>N/A</b>		16 SOCIAL SECURITY NO. <b>N/A</b>	
17 INFORMANT <b>LCDR George V. Zeberlein, USN, 6441 North-</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pseudomonas meningitis secondary to</b> DUE TO <b>myelomeningocele</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS ALTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (if this hospital) attended the deceased from <b>Sept. 24</b> , 19 <b>66</b> , to <b>Oct. 13</b> , 19 <b>66</b> , that (if) (we) last saw the deceased alive on <b>Oct. 13</b> , 19 <b>66</b> , and that death occurred at <b>725A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Jerry J. Tomasovic</b>		22b. DATE SIGNED <b>Oct. 14, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jerry J. Tomasovic, M.D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>Oct. 17, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR / <b>Murphy Funeral Home</b> ADDRESS <b>3524 Columbia Pike, Arlington, Virginia</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 20 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

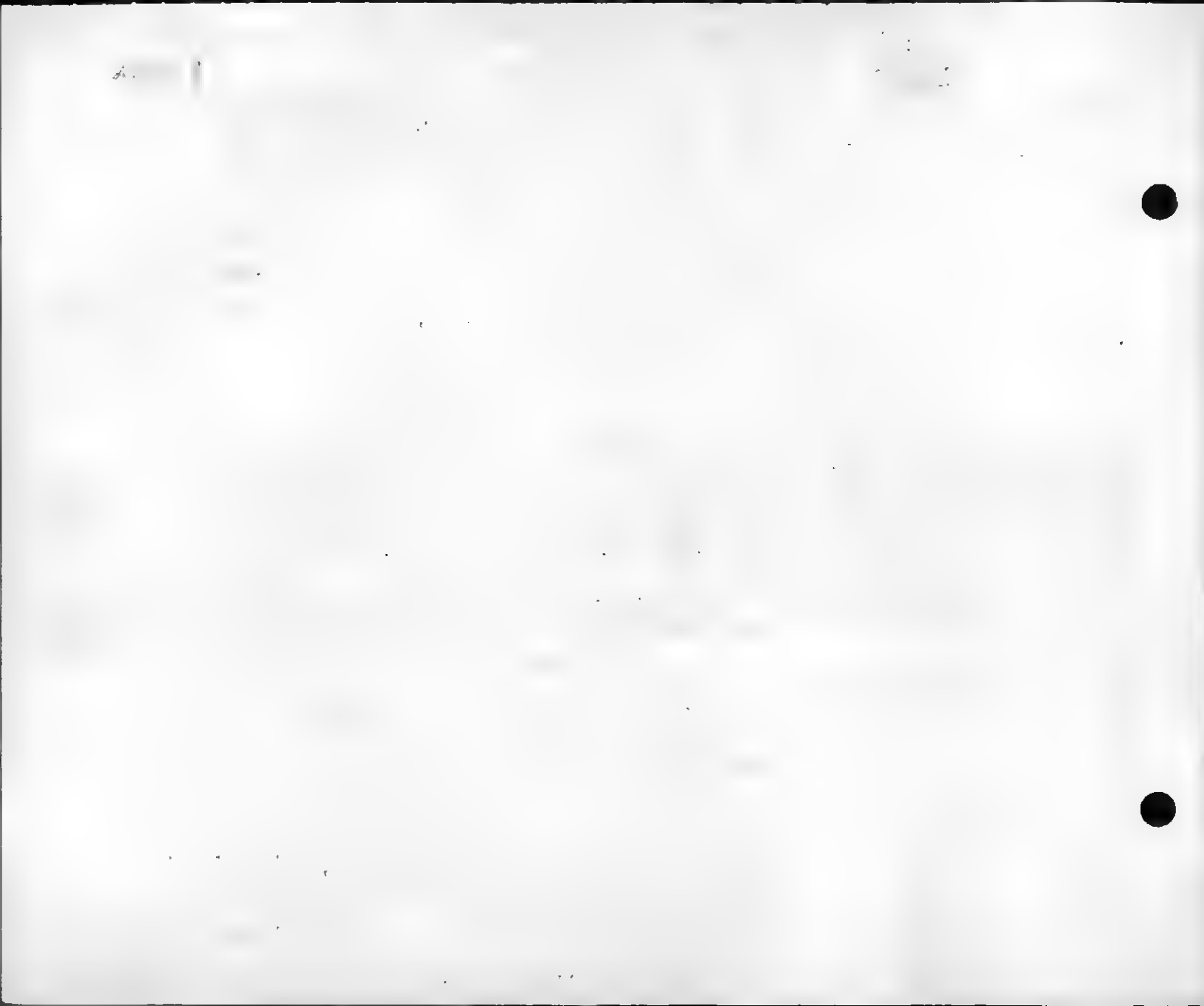


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Approved by Dr. Kemp

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14508					CERTIFICATE OF DEATH			14508	
1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>					d. STREET ADDRESS <b>12637 Georgia Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>LOUIS</b> Last <b>ZEMSKY</b>					4 DATE OF DEATH Month <b>October</b> Day <b>4</b> Year <b>19 66</b>				
5. SEX <b>Male</b>		6 COLOR OR RACE <b>White</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B DATE OF BIRTH <b>Mar. 30, 1916</b>		9 AGE (In years last birthday) yrs <b>50</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>		11 BIRTHPLACE (County & State, or foreign country) <b>New York</b>			12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13 FATHER'S NAME <b>Harry Zemsky</b>					14. MOTHER'S MAIDEN NAME <b>Rebecca ? ? ? ?</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W. W. II</b>			16 SOCIAL SECURITY NO <b>092-05-9263</b>		17 INFORMANT Address <b>Jean Zemsky, Same as 2</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>metastatic Carcinoma of Colon</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Carcinoma of Colon</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>5 years</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>5/25/66</b> , 19__, to <b>10/4/66</b> , 19__, that (I) (we) last saw the deceased alive on <b>9/26/66</b> , 19__, and that death occurred at <b>7:54 A.M.</b> from causes and on the date stated above.									
22a. SIGNATURE <b>Samuel Diener</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>10/4/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Samuel Diener</b>					22d. ADDRESS <b>4201 Mass. Ave., N. W. Washington, D. C.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-5-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beth David Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Elmont, L. I. N. Y.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Goldberg Funeral Home 4217 9th St., N.W.</b>					25a. REC'D BY REGISTRAR <b>OCT 7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14509 CERTIFICATE OF DEATH 14509									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			c. LENGTH OF STAY IN ID <u>1 year</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10903 Amherst Avenue</u>					d. STREET ADDRESS <u>10903 Amherst Avenue</u>				
3. NAME OF DECEASED (Type or print) First <u>Galina</u> Middle <u>Znamenskaja</u> Last <u>Znamenskaja</u>					4. DATE OF DEATH Month <u>October</u> Day <u>23</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sep. 21, 1901</u>		9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Warsaw, Poland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Gregory Moskvina</u>					14. MOTHER'S MAIDEN NAME <u>Sofia Stanishevski</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Eugenia Kourilo</u> Address <u>10903 Amherst Ave. Wheaton, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY DISEASE</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSION</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>2 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>JULY 1, 1964</u> to <u>10/23, 1966</u> , that (I) (we) last saw the deceased alive on <u>10/21 1966</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Bruno Kolarica M.D.</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/23/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>BRUNO KOLARICA</u>					22d. ADDRESS <u>4400 STAMP RD. MARLOW HILLS-MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Oct. 25, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>		
24. FUNERAL DIRECTOR <u>Clark E. Wisor</u> <u>Warner E. Pumphrey, Inc.</u>					ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 25 1966</u>		
					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14510

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14510

1. PLACE OF DEATH a. COUNTY <u>Mont. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>4611-47th. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Kenneth Joseph Zoeller</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>29</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/28/98</u>	
9. AGE (In years last birthday) <u>68</u> Yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>8</u>		11. IF UNDER 24 HRS. Hours <u>15</u> Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Adm. of traffic affairs - Government</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Zoeller</u>				14. MOTHER'S MAIDEN NAME <u>Hellie Griffin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes. WWI and II</u>				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Maryjorie Zoeller</u> Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Years.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/29/66</u>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-2-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>				25a. REC'D BY REGISTRAR <u>DATE NOV 3 1966</u>			
5130 Wisc. Ave. N.W. Wash. DC.				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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